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Missouri Medicine

Journal of the Missouri State Medical Association January 1997

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- ☐ 1997 Legislative Issues
- ☐ Managed Care Recommendations to the General Assembly
- ☐ Listing of Legislators and Maps of Legislative Districts
- ☐ Write a Letter to Your Lawmaker! Sample Letters Enclosed
- ☐ MSMA's Key Contact Program

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Evaluating the Financial Components of Capitated Managed Care Contracts

Supervising RNs and Advance Nurse Practitioners: New Regulations in Missouri

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"Missouri Capitol in January" Permission granted by the Missouri Division of Tourism.

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"Kids Caught in the Middle"

J. Regan Thomas, MD, Editor

I have discussed inappropriate actions by tobacco companies in this column several times in the recent past. The tobacco industry seems to have focused significant attention on potential youthful smokers. As has been pointed out previously, this is not a recent event but rather an ongoing pattern of activity for many years. Now yet another example has become public.

A byline story by Doug Levy in USA Today reports on documents that contradict the industry's denials that they studied ways to market cigarettes to youthful smokers. Philip Morris tobacco company according to this report polled teenagers in 1974 to find out why they would choose one cigarette brand over another. In a report title "The New Competition for Marlboro's Franchise" the data from interviews with 1,879 smokers under 25 including 693 who were "18 or less" was presented. Philip Morris hired the Roper Organization to prepare the survey for them. This is in contrast to their claims that since the 60s they do not study or market to teenage or youthful smokers. Maybe, but an increasing litany of reports seems to indicate otherwise. Another report reveals a Philip Morris memo from 1981 indicating the company's interest in the youth market. They seem to be good at it too. Sixty percent of children who smoke, smoke Marlboro.

This information comes to light during a period when debate continues over the role of the FDA in controlling tobacco and the search for a replacement for tobacco opponent David Kessler, M.D., as FDA commissioner. In the meantime, tobacco companies, advertisers, and distributors have filed suit in federal court to block the FDA's jurisdiction over tobacco products. Now the AMA and several other groups have become involved by filing "friend of the court" briefs. The other groups include the American Academy of Pediatrics, American College of Preventative Medicine, American Public Health Association, American Medical Women's Association, and the National Center for Tobacco-Free Kids. Now ads have been running on CNN (sponsored by the National Center for Tobacco-Free Kids) throughout December and January to support the FDA regulations and highlight that teenagers are being inundated with cigarette marketing.

As we all watch this unfold, keep in mind that 82% of Americans who smoke, started as children. Remember that according to AMNEWS, "nearly one in five eighth graders smokes cigarettes".

All of this activity is transpiring, all the accusations are met with denials, all the statements seem to be contradicted by the records, and all the while it seems it is the kids who are caught in the middle. This is a major public health issue for our country. It is imperative that we protect our children. MoMed

Mr. Steve Wetzell
Bloomington, MN

MSMA General Session

April 11, 9:00-10:30 a.m.

Mr. Steve Wetzell is the executive director of the Buyers Health Care Action Group (BHCAG), a coalition of 24 Twin City-based employers providing health care for 400,000 employees, retirees, and dependents throughout Minnesota, western Wisconsin and eastern North and South Dakota.

MSMA General Session

April 11, 2:30-4:00 p.m.

Edward Hirshfeld, JD
Chicago, IL

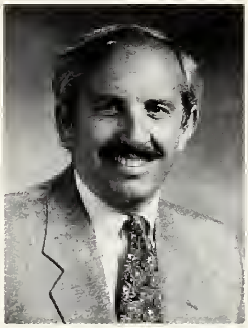
Mr. Edward Hirshfeld is Vice President and Associate General Counsel for Health Law of the American Medical Association (AMA). He directs the Health Law Division of the AMA, which is responsible for medicolegal policy initiatives and for counseling the Association about health law issues. The Health Law Division is responsible for coordinating the AMA's initiatives in the managed care area.

Robert F. Leibenluft
Washington, D.C.

Mr. Robert F. Leibenluft is Assistant Director for Health Care of the Federal Trade Commission's Bureau of Competition. Mr. Leibenluft writes and lectures extensively on health law topics. His articles on health care have appeared in The New England Journal of Medicine, Vanderbilt Law Review, The American Journal of Psychiatry, Business and Health, Pharmaceutical Executive, Medical Devise & Diagnostic Industry, The BBI Newsletter, and other books and journals.

Organized Medical Staff Section General Session

April 12, 10:00 a.m. - 12:00 noon



Joseph Green, PhD
San Diego, CA

Joseph Green, PhD, has served as Director of Continuing Medical Education and Vice President of Medical Education for Sharp HealthCare, an integrated health care system in San Diego, Ca., since 1989. He is also president of Professional Resource Network, Inc., a consulting firm which has provided assistance to several national specialty societies, medical schools, voluntary associations, and hospitals.

Robert Pyatt, Jr., MD
Chambersburg, PA

Robert Pyatt, MD, is serving as the acting Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians. He has been serving for the past four years as an ACCME national surveyor. Dr. Pyatt has been selected to serve on the Board of Examiners with the 1996 Malcolm Baldridge National Quality Award; only a few physicians in the United States are selected for this honor, and he is the first member of the CME community who has achieved this status.

"Managed Care or Managed Money"

Daniel O'Sullivan, MD, MSMA President

Parents become exposed to a basic principle of accounting, sort of a fundamental theorem on which business management education is based. Our children seem to discover this method in the process of the evolution from totally dependent to free spirit. This intermediate position involves checkbook management and balancing. If a college student wants money for beer and pizza or rock concerts he or she will simply not pay the phone bill or a credit card balance or some other fixed expense. Then at the pressure point, the same student calls home with that well-known catchy phrase, "great fun, need "mon," your son." Instead of responding, "So sad, too bad, your dad," most of us crumble and pay the bill. The lesson learned by all in this process is this: If you want your check balance to look better than it is simply don't pay your bills.

Recently United Health Care, following the advice of one of its financial boy wonders, accidentally discovered this business principle - they quit paying their bills. Physicians throughout the state of Missouri had payments for services withheld under the guise that United Health Care had a new computer system which was incapable of paying its debts. It's the old "Beer and Pizza" gag.

"Fee blocks, tough rocks, dumb docs."

Letters to providers (nee doctors) from H. Richard Grisham, then chief operations officer, stated that the computer glitch prevented payments, some more than ninety days overdue. The implication was clear that this was medical loss, not reimbursement for services already rendered and that UHC would, out of the kindness of their hearts, advance part of the money if the provider qualified and promised to pay it back later.

What an incredible fable has been proposed for our Christmas consumption! Patients or their employers pay money for insurance to cover the employees's health care and big brother will decide who qualifies for an advance of money earned three months ago.

It is unclear how much is involved in this "withhold" but one cardiology group was behind $200,000 and other groups nearly that. It is estimated the bill is in the millions. Meanwhile the new computer system is probably being paid for by the interest on the float while doctors scramble for year-end malpractice payments. This is a fact of managed care most of us were not clever enough to anticipate - but don't expect much sympathy.

Would you believe that one of the most profitable corporations on the stock exchange with profits as much as 32 percent would allow itself to become financially disabled by a planned computer improvement? If you do believe that , I have an oil well in Oklahoma I would like to sell you. "Fee blocks, tough rocks, dumb docs." MoMed

1995 Medical Malpractice Insurance

Loss ratios by type

	Premiums Earned	Losses Incurred	Loss Ratio
Physicians	$88,245,253	$51,227,401	58.05%
1995 Total (1)	122,170,723	61,718,236	50.52%
Physicians	83,088,562	42,955,660	51.70%
1994 Total (1)	117,860,545	65,449,209	55.53%
Physicians	68,982,827	45,651,292	66.18%
1993 Total (1)	101,049,704	57,543,001	56.95%
Physicians	765,761,365	456,836,622	59.66%
Ten Year Totals	$1,115,186,599	$636,675,380	57.09%

(1) Includes all types of health care providers: physicians, hospitals, dentists, nurses, and others

1995 Medical Malpractice Insurance

Experience by Company - Physician data only

Company	Market Share	Premiums Earned	Loss* Adjustment Expense	Loss Ratio
Medical Protective	27.64%	$23,843,743	$18,181,847	49.70%
PIE Mutual	20.93%	17,186,577	1,356,670	85.80%
Medical Defense	14.57%	13,317,815	3,559,219	71.83%
Mo. Medical Ins.	14.26%	11,765,349	4,161,790	36.68%
Intermed (RCA)	10.95%	12,867,268	1,976,403	42.06%
	88.35%	78,980,752	29,235,929	
Totals	100.00%	$88,245,253	$30,731,687	58.05%

*The cost involved in an insurance company's adjustment of losses under a policy.

Source: Missouri Department of Insurance

For a copy of the Missouri HMO Report 1995, send $35 to: Missouri Department of Insurance, P.O. Box 4001, Jefferson City, MO 65102. Attention: Statistics.

The Hook that Kills . . . Missouri's Children Are Being Hooked on Cigarettes at a Much Younger Age

J. Michael Zylka, PhD, MD, FACP

If there really is a tobacco war being waged, Pat Lindsey is on the front line. As the project coordinator for St. Louis ASSIST (American Stop Smoking Intervention Study for Cancer Prevention) she produces programs to teach children about the dangers of tobacco.

"We started putting the program on for 8th graders," Lindsey said, "But we discovered that we were too late. Many of them already were addicted, and in fact would sneak out to the bathroom during breaks for a smoke. So, now we're putting the programs on for sixth graders."

Lindsey is seeing firsthand what study after study has found: children are being hooked on cigarettes at a younger age. "At one of our recent programs, a teacher from a suburban district introduced a 6th grader who was a regular smoker. What shocked me is that she has been smoking since she was in the third grade."

Tobacco is taking a terrible toll on our young people. According to the FDA, about three million American adolescents currently smoke with another one million young people becoming regular smokers every year. Approximately one out of every three of these young people will die prematurely as a result. Approximately three quarters of adult smokers took up the habit before they could legally purchase cigarettes and before they fully understood the health risks of tobacco.

Kids are experimenting with cigarettes at a younger age. A survey reported in December 1995 that the proportion of 8th and 10th graders who reported smoking in the previous 30 days had risen by a third since 1991.

Unhappily, smoking among teenagers has risen to nearly 22% for high school seniors, according to the latest data from the National Centers for Disease Control and Prevention. Because of the addictive nature of nicotine, too few of these kids will quit smoking until much later in life.

Tobacco use kills more Americans than AIDS, car accidents, alcohol, murders, illegal drugs, suicides, and fires combined. Nearly 500,000 Americans will die this year from smoking-related causes.

> ***Research indicates that young people are especially sensitive to the price of a pack of cigarettes. Generally, each one percent increase in the cost of a pack of cigarettes will lead to a one percent decline in teenage consumption.***

So how do we keep young people from smoking in the first place? Experts say it will take a strong commitment and a multifaceted effort to make tobacco less alluring to children. No one can underestimate impact education programs can have on most young people. That's why groups like the American Cancer Society and ASSIST put on programs for tens of thousands of Missouri young people each year. The programs include horrifying testimonials from victims of tobacco and family members to shock youngsters.

But, telling kids that smoking will hurt them and eventually will cut short their lives by itself will fall far short.

"Everyday, kids are bombarded by messages that promote smoking as being cool, rebellious, adult, sophisticated, and sexy," Lindsey said. "We're lucky if we get one shot at the kids every two to three years." According to one study, nearly as many six-year-olds could identify Joe Camel as they could Mickey Mouse.

In August 1996, the Food and Drug Administration implemented new rules to reduce the number of tobacco advertisements that appeal to young people. The rule limits advertising to black-and-white, text-only format to ensure that advertising will not be used to create demand for cigarettes among young people. The distribution of non-tobacco items, such as hats and tee shirts that carry cigarette logos, such as Joe Camel, will be prohibited. Sponsorship of sporting and other events will be limited to the corporate logo only.

Limiting tobacco advertising is one thing, but in Massachusetts, citizens are fighting fire with fire. Voters approved a cigarette tax increase which has created a $100 million a year pool of money to create an educational offensive. With the money, the state has hired a top flight advertising agency which has created more than a dozen 30-second television commercials, each with a message for a targeted audience.

Although it is too soon to tell whether the Massachusetts television blitz is working, there is evidence that such campaigns are effective. From July 1, 1967 to December 31, 1970, the Federal Communications Commission, as part of the Fairness Doctrine, required broadcasters to provide time for antismoking messages on radio and television. One antismoking commercial aired for every three or four cigarette ads until they were banned in 1971.

For three years, the American people were exposed to both pro- and antismoking messages. What is remarkable is that for the first time since the 1930s, per capita cigarette consumption has dropped for three straight years. When the antismoking messages ended on television, cigarette consumption began to rise again.

Tobacco use kills more Americans than AIDS, car accidents, alcohol, murders, illegal drugs, suicides, and fires combined. Nearly 500,000 Americans will die this year from smoking-related causes.

Cigarette tax increases are an effective way to reduce teen smoking in another way. Because young people don't have much money, increasing the cost of a pack of cigarettes makes it less likely that they will become regular smokers.

There is a correlation between tobacco taxes and a state's smoking rate, according to the U.S. Office on Smoking and Health. The higher the tax, generally speaking, the lower the smoking rate. The smoking rate in Missouri, which has one of the lowest tobacco excise taxes in the country, is higher than the national average among both adults and teenagers. The death rate in Missouri from smoking-related causes is the twelfth highest in the country, according to the study.

The ***Washington Post*** reported that higher tobacco excise taxes led to less use of tobacco products. An August 1995 article cited that in Michigan a 50-cent-a-pack increase lead to a 30% drop in cigarette sales. Along the same line, Michael Moore, of the Duke University Fuqua School of Business, found that a 10% increase in tobacco excise taxes "is projected to save approximately 5,200 lives a year."

The research also indicates that young people are especially sensitive to the price of a pack of cigarettes. Generally, each one percent increase in the cost of a pack of cigarettes will lead to a one percent decline in teenage consumption. The Government

Continued on page 10

Continued from page 9

Accounting Office concluded in a 1989 report that a higher tobacco excise tax should significantly reduce the number of teen smokers.

An interesting fact is that over the years as we have learned more about the devastating impact smoking has on health, the relative tax on cigarettes has dropped. In the mid 1950s, a pack of cigarettes cost about a quarter, with the tax being roughly half of the cost. By 1994, the average price of a pack of cigarettes rose to $1.76, but the tax had dropped to just over a quarter of the cost. What's more, the tax on cigarettes falls far short of the cost of treating tobacco related illnesses.

Nationally, treating illnesses caused by smoking cost about $50 billion in 1993, which works out to $2.06 per pack. The average combined federal and state cigarette tax is just 50 cents a pack. (National Centers for Disease Control and Prevention, 1994)

Cigarette smoking is the largest single drain on the Medicare Trust Fund, poised to take $800 billion over the next 20 years, according to a study of hospital records and epidemiological studies. (Center on Addiction and Substance Abuse, Columbia University, May 17, 1993)

The United States has the lowest tax on cigarettes of any industrialized nation. Canadian smokers pay $3.26 per pack and in many other countries pay about $2 per pack. (Non-Smokers Rights' Association, Canada, Sept. 24, 1993)

In Canada, youth smoking rates have dropped by almost two-thirds since 1980. Across Canada, the percentage of teenagers who smoke dropped from 42 percent to 16 percent. (C. Everett Koop, U.S. Surgeon General, Canada's Non-Smokers' Rights Association)

Convincing the Missouri General Assembly to increase the excise tax on cigarettes would be difficult, according to St. Louis political consultant John Angelides, the former news director at KMOX Radio. "Anything is possible," Angelides said. "But in this day and age voting to raise taxes is perceived to be hazardous to your political health."

That means an increase in the cigarette excise tax would need to go to a statewide vote of the people by initiative petition. To do so, supporters would have to collect tens of thousands of signatures, then wage a campaign against the tobacco companies, who would spend millions of dollars of their unlimited resources to defeat such a proposition.

> ***Tobacco is taking a terrible toll on our young people. According to the FDA, about three million American adolescents currently smoke with another one million young people becoming regular smokers every year.***

Impossible you say? It's been done before. In Arizona, health advocates waged a similar David versus Goliath fight. They asked voters to approve a 40 cent cigarette tax increase in a state where the voters are skeptical about government and angry about their tax burden.

Supporters fought an air war and a ground war. On the ground, they were able to mobilize thousands of volunteers to spread their message and respond through the news media to attacks from the tobacco companies. In the air, although they were outspent by the tobacco companies on television, they had a strong message. Their 30-second spots informed voters that the cigarette tax would reduce smoking, particularly among children and teenagers and that the tobacco companies would spend any amount of money and say anything to scare them into voting no.

The ads were effective. The tobacco tax passed by a 52% to 48% margin. "It would not be easy to replicate those results in Missouri," said Washington-based media consultant Glenn Totten of Totten Communications. "But, with the right coalition, the right message, and the political will, it could be done." MoMed

Dr. Zylka is Director of the St. Louis ASSIST Coalition, Secretary of the St. Louis Metropolitan Medical Medical Society, and MSMA Third District Councilor.

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An Income-Based Approach for Evaluating the Financial Components of Capitated Managed Care Contracts

Gordon R. Hanebutt, MBA

There are several different ways to evaluate the financial impact associated with signing a managed care contract that provides reimbursement on a per member per month or capitated basis.

The three most frequently used methods of evaluating capitation rates are: 1) comparing the capitation rate to the physician's current fee schedule. An example of this methodology was presented in the March 1996 issue of Missouri Medicine, pages 116-188; 2) comparing the capitation rate to the Medicare fee schedule; 3) comparing the capitation rate to some estimate of cost. Although each of these three methods can provide some insight into the attractiveness of a given reimbursement level, there are problems and limitations associated with each of these evaluation tools.

Comparing the capitation rates to the practice fee schedule can lead to erroneous conclusions since most third party payors reimburse at some amount less than fees. In addition, the fee schedule itself may be structured improperly and/or old and not updated. Comparing to the Medicare RBRVS allowable provides another benchmark. This method only gives a comparison to a fee schedule that may only apply to 30 to 40 percent of your practices volume. Comparisons to cost may provide some insight as to the attractiveness of the capitation levels, but which type of cost is the most appropriate to compare to? Full cost? Direct cost? Incremental Cost?

The fundamental question that needs to be asked when evaluating a managed care contract is:

If I sign this contract to what extent will it help enhance or detract from my current income level?

To evaluate the financial impact of signing a capitated managed care contract, employ an income-based approach.

To answer this question one needs to employ an income-based approach to evaluating capitated managed care contracts, such as the one that is outlined on the following pages.

To simplify the calculations, this model assumes that the new contract will comprise 100% of your business. This will in reality almost never be the case. Upon completion of this evaluation if you have an estimate of the percent of your practice that the new contract will represent, the calculation can be expanded to provide a precise estimate of future periods income levels. That calculation is beyond the scope of this introductory article. This example of the calculation is for a primary care physician contract, however, the same process can be employed, with modification, to evaluate specialty capitation contracts.

The Income-Based Evaluation Model

Steps to completion and sources for data.

- Determine the current number of visits per day for the physician through a review of records or through an interview process.

- Determine the number of days worked per year, after taking out vacation, holidays, weekends, days off and illness.

- Use the data identified in steps number one and two, above, to determine the total maximum visits.

- Obtain the estimated number of visits per member per year for this specialty and this population. This can be obtained from a consulting firm with expertise in this area or an acturial firm.

- Calculate the average expected capitation reimbursement PMPM from the age/sex banded tables provided by the health plan. This can be obtained from a consulting firm with expertise in this area or an actuarial firm.

- Calculate the annual expected capitation.

- Determine the average expected co-pay to be sold in the market.

- Calculate the expected annual co-pay revenue.

- Identify any exclusions that can be billed fee for service in addition to the capitation payment.

- Obtain the last years charges, for all patients, by CPT code in descending sequence.

- From the list identified in preceding step, identify what exclusions can be billed fee-for-service.

- Obtain the allowable for the fee-for-service items in preceding step. This should be available from the health plan.

- Calculate the expected reimbursement from these exclusion items.

- Sum the expected reimbursement from capitation, co-pay's, and exclusions.

- Obtain an estimate of the practice overhead.

- Reduce the revenue by the overhead amount.

- Compare this to the physician's net income before taxes last year. This is available from your accountant or by looking at your tax returns.

- Calculate the percent increase or decrease.

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Income-Based Evaluation Worksheet
Example of Calculation

	Data	Row #
Current number of visits per day	30	1
Days worked in a year	240	2
Total maximum visits (row 2 x row 3)	7,200	3
Estimated Visits PMPY	2.2	4
Theoretical Maximum member panel (staffing ratio) (row 3/row 4)	3,273	5
Average Capitation PMPM	$10	6
Annual Capitation (row 5 x row 6 x 12 months)	$392,727	7
Average Co-pay	$7	8
Co-pay revenue (calculated) (row 3 x row 8)	$50,400	9
Exclusion Revenue	$50,000	10
Total Reimbursement (row 7 + row 9 + row 10)	$493,127	11
Overhead Percent	50%	12
Profit (row 11 x row 12)	$246,564	13
Current W-2 Income Level	$150,000	14
Percent better (worse)	%64	15

Summary

In this fictitious example the contractual reimbursement level being reviewed would produce an annual income level of $246,564, if we could replace 100% of our practice with patients at this reimbursement level. This resulted in a 64% increase over the income level shown in the example. In this example we have learned that this is a very favorable contract and we should identify and employ techniques to increase the volume from this payer. If, on the other hand, this analysis had shown that the capitation rates reduced the current income level we should implement measures to limit the extent of volume that this contract represents in the practice.

If you desire the actual increase or decrease in income expected from the volume associated with this contractual arrangement can be calculated. To do this one needs to estimate the number of members in the plan that will choose to be in your panel and then calculate the volume and reimbursement level associated with this patient population. Rarely, does this next level of calculation need to be performed. It is usually quite clear, from a decision-making and negotiating perspective prior to going to this level of detail, if the contract in question is attractive or not attractive. MoMed

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Council directs action on prescription policy

The following actions were approved at the MSMA Council Meeting, Nov.17, 1996, in Jefferson City.

The MSMA Council directed the Committee on Legislative Affairs to develop legislation prohibiting therapeutic substitution of B-rated generic drugs in Missouri by either instate pharmacies or out-of-state mail order companies in accordance with AMA policies during the Council Meeting on Nov. 17 in Jefferson City.

The Committee will also explore possible legislation to prohibit out-of-state therapeutic substitutions of prescriptions in accordance with current policy. Part of this effort includes educating its membership to specify A-rated generics when authorizing generic drug substitutions on the state-approved prescription form. MSMA also announced its position on generic substitution, i.e. when a physician allows for generic substitution, only FDA A-rated generic drugs should be substituted.

The Committee on Legislative Affairs was directed by Council to support the Board of Healing Arts in its efforts to make several changes in Missouri's licensing statutes. Council also instructed MSMA staff to continue to pursue the statute of limitations legislation; to seek passage of legislation to require HMO medical directors to be licensed to practice medicine in Missouri; and to have its breast reconstruction insurance coverage bill reintroduced in 1997.

In other Council Actions:

The Council approved MSMA's 1997 operating budget of $1,682,970.00.

The Council approved MSMA filing an official complaint with the Missouri Department of Insurance and/or the Attorney General's office regarding the nonpayment of valid claims by United HealthCare.

The MSMA Executive Committee will study the development of a policy statement on mergers of hospitals (or other treatment facilities) and insurance companies as not being in the best interest of patients. If appropriate, the Executive Committee is to present this statement to the Attorney General's office and the Eighth Circuit Court. A resolution on this subject is to be developed for presentation at the 1997 Annual Convention.

The MSMA Council endorsed a mission statement proposed by MAOPS and the Missouri Association of Local Public Health Agencies on formalizing the role of physicians in public health departments and will reconsider the proposed job description for a medical director of local public health agencies when a final version is available.

MSMA will develop a statewide mini-internship program (in conjunction with the component medical societies) whereby local news media, attorneys, businessmen, and lawmakers would shadow a practicing physician. MSMA's Key Contact Network will be utilized for this program.

The Council directed MSMA President Daniel O'Sullivan, MD, to appoint an ad hoc committee to make a single recommendation on the issue of AMA Delegation apportionment to be presented at the pre-convention Council Meeting in April. The Council also tabled the issue of current MSMA policy on funding for AMA candidates until the January Council meeting.

The MSMA Young Physicians Section was directed to study the credentialing problems encountered by new physicians trying to contract with an HMO.

MSMA's Executive Committee will study the Medical Student Section's request to utilize the Association's Health Education Foundation as a depository for tax-free donations to help sponsor their preceptorship program that will begin in the summer of 1997. The Executive Committee will also research a proposal by the

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Medical Student Secion to develop a membership lapel pin for students and physicians.

The Association's Membership Division will inquire of physicians why some do not renew their MSMA membership in order to gain insight on membership benefits.

The Council approved proxy for Drs. Daniel O'Sullivan, A.J. Campbell, Stephen Vilmer, William Dorzab and Mr. C. C. Swarens to vote MSMA stock in MSMS at its Annual Meeting in January.

The appointment of J. Michael Zylka, MD, to fill the unexpired term of Randall Treadwell, MD, as Third District Vice Councilor was endorsed. MSMA also voted to support the candidacy of Jo-Ellyn Ryall, MD, for the AMA Council on Constitution and Bylaws.

The Council approved the following reports and their recommendations: President's Report; Report of the Executive Vice President; Report of the Physicians' Health Committee; Report of the Commission on Medical Education and Health Manpower; Report on MoMed Net; Report of Commission on Public Affairs; Report on Cancer Control Project; Report of the Commission on Interspecialty Medicine; and the Report on the conference of family violence including the recommendation that MSMA publish on a regular basis family violence issues.

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Proposed MSMA Constitution Changes

The following proposed changes in the MSMA Constitution were presented at the 1996 meeting of the House of Delegates and will be voted on during the 1997 Annual Convention.

Article ~~IV~~ III. House of Delegates

Article ~~V~~ IV. Council. The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, the duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physician Section, and the ~~Hospital~~ Organized Medical Staff Section. A majority of voting members of the Council shall constitute a quorum.

Article ~~VI~~ V. Council on Ethical and Judicial Affairs

Article ~~VII~~ VI. Sessions & Meetings

Article ~~VIII~~ VII. Officers. Section 2. The Officers shall be elected annually. The term of Councilors and Vice-Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor, and ~~hospital~~ organized medical staff Councilor, who shall each be elected to a one-year term.

The Delegates from the Medical Students Section, the Resident Physicians Section, and the ~~Hospital~~ Organized Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor.

Article ~~IX~~ VIII. Funds, Expenses and Budget

Article ~~X~~ IX. Referendum

Article ~~XI~~ X. Seal

Article ~~XII~~ XI. Amendments. The House of Delegates may amend any article of the constitution by a two-thirds vote of the delegates present and voting in any Annual Convention, provided that such amendment shall have been ~~presented in the previous open meeting of the House of Delegates and that the amendment shall have been~~ published twice during the year in the Journal of the Association or sent officially to each component society at least two months prior to the meeting at which final actions is to be taken.

~~**Article III. Membership.** Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association.~~

Supervising RNs and Advance Nurse Practitioners: New Regulations for Missouri

Katharine C. Rathbun, MD, MPH and Edward P. Richards, JD, MPH

In 1993, the Missouri legislature passed a health care reform bill. Among other issues, it dealt with the extent to which nurses could see patients and provide treatment without direct physician supervision - what Missouri calls collaborative practice between physicians and nurses. The law requires the Boards of Registration for the Healing Arts, Nursing, and Pharmacy to issue joint regulations on collaborative practice. After three years of negotiation, regulations were published on August 1, 1996 and became effective September 30, 1996. These regulations provided specific information about the required terms of a collaborative practice agreement. They also protect nurses from demands that they work with inadequate physician backup, and protect physicians from being forced to supervise too many nurses.

Previous Regulations for Supervising Nurses

Prior to the 1975 amendments to the Nurse Practice Act, all nurses in Missouri were expected to work under the direct supervision of a physician. In response to changes in medical care delivery, the Legislature modified the Act in 1975 to broaden the authority of nurses. In the 1983 case of *Sermchief v. Gonzales*, [1] the Missouri Supreme Court reviewed a petition for declaratory judgment brought by five nurses and two physicians to avert threatened actions by the Board Healing Arts for the unauthorized practice of medicine and aiding and abetting the unauthorized practice of medicine.

Under the 1975 revised Nursing Practice Act, professional nurses were given the right to do: "(b) Assessment, nursing diagnosis, nursing care, and counsel of persons who are ill, injured or experiencing alterations in normal health processes."[2] The Missouri Supreme Court saw the question as whether these nurses were making nursing diagnoses as allowed by the statute. The Court's finding is still important because there have been no changes in the Nursing or Medical Practice Acts which would lead to a different finding today:

> *"The acts of the nurses herein clearly fall within this legislative standard. All acts were performed pursuant to standing orders and protocols approved by physicians. Physician-prepared standing orders and protocols for nurses and other paramedical personnel were so well established and accepted at the time of the adoption of the statute that the legislature could not have been unaware of the use of such practices. We see nothing in the statute purporting to limit or restrict their continued use . . . There can be no question that a nurse undertakes only a nursing diagnosis, as opposed to a medical diagnosis, when she or he finds or fails to find symptoms described by the physician in standing orders and protocols for the purpose of administering courses of treatment prescribed by the physician in such orders and protocols."*[3]

This establishes the basic standard for supervising nurses in Missouri. The nurses do not need to be under the direct (physical) supervision of a physician if they are following standing orders or protocols that spell out the specific signs and symptoms required for a diagnosis, the actions to be taken or medication to be used for a given diagnosis, and that the patient must be referred to the physician if the condition is outside of the proto-

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col or orders. A nurse in a covered job, which would include private office and clinic nurses, is always tied to a supervising physician. The nurse's authority to render care and administer drugs derives from the physician's license and not the nurse's license.

The New Standards

In 1993, the Legislature added a definition of an Advanced Practice Nurse to the Nursing Practice Act.[4] While this has been seen as a sweeping reform, it actually made very few changes in the existing law. It did not modify the allowable scope of practice for nurses in the new category. APNs remain under the same supervisory restrictions as RNs.

The Legislature also modified the Medical Practice Act to allow physicians to delegate certain tasks to nurses through the use of collaborative practice agreements:

"Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to a registered professional nurse the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the registered professional nurse and is consistent with that nurse's skill, training and competence."[5]

While the language is arranged differently, the only substantive difference in the provision governing delegation to APNs is that they may be delegated the right to prescribe as well as administer or dispense drugs.

These amendments and definitions do not expand the authority of RNs or APNs to practice without physician supervision. Consistent with the Missouri Court's interpretation of the Nursing Practice Act, the amendments only allow RNs and APNs to make nursing diagnoses. As discussed, in the *Sermchief* case, making a nursing diagnosis means determining whether the patient falls under the medical diagnosis defined by the physician in the standing order or protocol. While the new rules promulgated by the Board of Healing Arts appear to expand the role of the APN to include making medical diagnoses under looser guidelines or agreements, the regulations do not change the underlying relationship. The nurse is practicing on delegated authority from the physician.

Establishing the Collaboration

Before entering into a collaborative practice agreement, the law requires that the physician must do several preliminary activities:

✔ The physician must work with the APN in the same clinic and directly supervise the APN for one month before the APN works at a remote site.

✔ The nurse must practice within 30 miles by road of the physician's principal practice site and be close enough to have an effective collaboration, (50 miles for a federally-designated HPSA).

✔ The physician must establish a system to review the "work, records, and practice" of the APN or RN at least once every two weeks and to document this review.

✔ The physician must be immediately available in person or by telecommunications at all times when the nurse is practicing.

✔ The physician must schedule time to work with the APN in the clinic at least once every two weeks.

✔ The physician must personally see all patients with new or significantly changed conditions as soon as practical after the APN visit. Under no circumstances may this be longer than two weeks.

What are the Requirements for a Collaborative Practice Agreement?

The written collaborative practice arrangement must contain certain specific provisions and it must include certain administrative procedures in addition to the protocols:

- It must be signed and dated by both the nurse and the supervising physician.

- It must indicate that both are aware of its content and agree to follow its terms.

- It must be kept (with all changes and revisions) for eight years after it is no longer in force.

- It must delineate a general scope of practice consistent with the skill and training of both the physician and the nurse.

- There must be written guidelines for consultation and referral to the supervising physician and for emergency services when warranted.

- There must be a written procedure for reviewing the nurse's work and the medical records every two weeks.

- There must be a written plan for promptly seeing any patient whose condition is beyond the nurse's scope of practice.

- There must be a written procedure for reviewing and managing abnormal test results.

- For an RN, there must be strict standard orders - "written agreement, jointly agreed -upon protocols, or standing orders that shall describe a specific sequence of orders, steps, or procedures to be followed in providing patient care in specified clinical situations."

- For an APN, there must be disease-specific protocols with clear criteria for making the diagnosis - "written agreement, jointly agreed-upon protocols, or standing orders that are specific to the clinical conditions treated by the collaborating professionals."

What is Forbidden

☒ Controlled substances require a direct order or prescription from the physician for each specific patient. RNs and APNs are specifically prohibited from prescribing controlled substances.

☒ Office dispensing by the nurse is limited to 72 hours worth of medication. Nurses may dispense samples to complete the therapy, but unlike physicians, they may not run an office pharmacy.

☒ Each collaborative practice agreement is between one nurse and one physician. A nurse or physician may enter into more than one agreement, but it must be clear at all times which specific physician is supervising the nurse.

☒ A physician may not supervise more than three full-time advanced practice nurses. More than one nurse may be counted together as a full-time equivalent.

☒ The physician cannot allow a nurse to further delegate services provided under a collaborative practice agreement.

☒ Physicians must not have collaborative practice agreements with more nurses than they can personally supervise, or with nurses who are actually under the control of others.

Collaborative Practice

Before entering into collaborative practice, the physician should consult with his or her medical malpractice insurance carrier, and attorney if the practice has one. The physician must be certain that all of these activities and patients are covered under the policy. This should be in writing in the form of a policy rider or a letter from the broker or insurance company. In addition, the nurse should have his/her own liability insurance. Without independent coverage, the nurse may be in a position of having to blame the physician to escape crushing legal costs.

There will be an increase in liability for the physician entering into collaborative practice for two reasons. First, federal productivity standards say that an APN should be able to see about half as many patient visits as a physician. The physician who is overseeing the maximum three APNs will more than double his/her patient load. Obviously, if the physician is responsible for the care of more patients, there is more liability exposure. Second, the physician is practicing through the actions of the APN. Very specific standing orders and protocols may reduce the chance for error and improve the quality of supervision, but they are still just substitute for the presence of the physician.

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Figure 1

Disease Specific Protocols

SAMPLE	STREP THROAT
A. Diagnostic Criteria 1. Each diagnosis is defined by a set of signs, symptoms and tests results which must be taken together to establish the specific diagnosis. 2. There may be several pathways to a given diagnosis. Differential diagnosis is not part of a strict protocol and should not be used.	**A. Diagnostic Criteria** 1. Positive throat culture or rapid strep test or 2. Swore throat and household contact to a patient with positive strep test.
B. Laboratory This states all the lab tests, x-rays, etc., that are required on a patient with this diagnosis. Some of the tests may be necessary to establish the diagnosis.	**B. Laboratory** Rapid Strep Test
C. Treatment This contains specific instructions for treatment of patients with this diagnosis. These are standing orders and should be clear and complete written orders.	**C. Treatment** 1. Amoxicillin 500 mg TID x 10 or 2. Erythromycin 250 mg QID x 10 (use the dose protocol for children)
D. Follow-Up All patients should be given a return appointment and specific instructions for follow-up.	**D. Follow-Up** 1. Return to clinic if not improved in 48 hours 2. Dipstick urine for protein in six weeks.
E. Epidemiology This authorizes treatment of contacts to the patient and specifies if the disease is reportable to the public health authority or the police.	**E. Epidemiology** 1. Treat all symptomatic family members if anyone has a positive lab test for strep. 2. Scarlet fever must be reported to the health department.
F. When to Refer This states the severity of disease or the special circumstances that require referral to a different protocol, to the supervising physician, to the emergency room, or for other services. This defines the scope of practice for the nurse.	**F. When to Refer** 1. If Otitis Media is present, use that protocol. 2. Consult physician if scarlet fever rash is present or if the patient cannot take either antibiotic. 3. Refer to the emergency room any patient with airway compromise or peritosilar abscess.
G. Notes This portion of the protocol is not binding on the providers. This is the place for clinical pearls and helpful hints.	**G. Notes** 1. Office strep tests are only 50% to 70% sensitive. 2. There is no set of signs and symptoms that reliably distinguishes strep throat from viral pharyngitis.

The key to good risk management in collaborative practice agreements is carefully crafted protocols and supervision procedures. All the procedures should be very clear about what the nurse may not do. Emergency procedures should be clear and concise in telling the nurse what to do to stabilize the patient and arrange transport.

The formulary should be limited and should state that the nurse may not prescribe any drug that is not on the list. Use specific drugs, e.g., ibuprofen not NSAIDS; and never list classes of drugs. Deciding what is the "appropriate antihypertensive" is a pharmacology course, not a standing order.

The protocols should follow a standard format and, under Missouri regulations, must be disease specific. (See Figure 1 for a general form for protocols and a specific example for strep throat.) This means that a Family Practice APN will need 50 to 100 protocols to work from. For registered nurses who are not APN's, the protocols must be strict standing orders. For APN's, the choices of therapy may be a little looser but the criteria for diagnosis should still be strict.

A number of books are available with disease specific guidelines to aid advance practice nurses. Unfortunately, these are generally designed for nurse advice lines or for situations where nurses have independent practice authority. Attached is a format for disease-specific protocols which may be helpful for nurses and physicians going into collaboration under Missouri regulations. These are standing orders for a diagnosis established by the doctor. The nurse evaluates the patient for specific signs, symptoms, and test results. If the patient does not fit a protocol diagnosis exactly, the nurse must refer that patient to the doctor immediately or contact the doctor for specific orders for that patient. Whether modifying old protocols or writing new ones, there is a great deal of work involved in establishing adequate protocols.

Conclusions

Collaborative practice agreements with advanced practice nurses are an effective way of improving access to medical care. While Missouri has now broadened the scope of physician-nurse collaborations, it still does not allow nurses to practice independently. They may do advanced practice only under the direction and supervision of a physician, as embodied in the collaborative practice agreement and the standing orders and protocols. The courts will hold that these written agreements and standing orders create a physician-patient relationship between the supervising physician and the patients that are seen by the nurse, with the attendant duties of supervision and vicarious liability.

Physicians must remember that these are only state laws and regulations, they do not change federal Medicare requirements for nursing supervision. The Medicare rules are much stricter, except in Federally Qualified Community Health Centers and Federally Certified Rural Health Centers. Unless the physician is physically present in the clinic, no one may bill Medicare for the work done by a nurse in a collaborative practice agreement. MoMed

References

1. Sermchief v. Gonzales, 660 S.W.2d 683 (Mo. 1983)
2. 335.016.9(b) R.S.Mo. (1995)
3. Sermchief at 689-690
4. 335.016 R.S.Mo. (1995)
5. 334.104.1 R.S.Mo. (1995)
6. 4 CRS 200-4.200(3)(F)
7. 4 CRS 200-4.200(3)(G)

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Legislative Issues - A Look Ahead

The 1997 Missouri General Assembly convenes at high noon on January 8, and will be in session until 6:00 p.m. on May 16. As always, health care issues will be high on the agenda of many legislators. Of the approximately 1,300 bills that will be introduced, some 300 of them may impact your practice. Some of the issues will be new, and many we have fought for years. This summer legislative leaders appointed a special Joint Interim Committee on Managed Care to assess the current status of managed care in Missouri and recommend needed reforms. A sweeping managed care reform bill could be the result of that Committee's work. A detailed report on this activity can be found on page 25.

While managed care reform tops our list of priorities, there are other very important issues. Following, in no particular order, is a sampling of the many other issues we expect to struggle with in 1997.

Lay Midwifery

The legalization of the practice of lay midwifery is an issue that has been around for several years. Portrayed by its advocates as an "access" issue, the bill inches closer to passage every year. A prospective lay midwife could have very little training or education and still be licensed by the state to deliver babies. MSMA considers this a significant safety issue and will lobby against its passage.

Definition of Emergency Services

MSMA again will be supporting its emergency physicians in an attempt to define "emergency services" for insurance purposes. In the absence of a specific definition, insurers have been denying payment for emergency room care when the ultimate diagnosis determines that the case was not a true emergency. We also hope to prohibit preauthorization for emergency services. The Joint Interim Committee on Managed Care has expressed support for these concepts, and is expected to include this language in its comprehensive managed care reform package.

Generic Substitution

For several years the pharmacy lobby has introduced legislation to allow pharmacists to make a generic substitution unless you, the prescriber, in your own hand, write the words "Brand Medication Necessary" across the face of the prescription form. This bill should be reintroduced in 1997, and MSMA again will oppose it.

Informed Consent for Mental Health Treatments

In 1995 and 1996, legislation was introduced to address the controversial issue of repressed memories and the so-called "false memory syndrome." The issue at hand is one that needs addressing, but this bill was significantly flawed. It would have imposed countless burdensome informed consent requirements on mental health providers, driving up the cost of providing care and impeding the delivery of needful services. Should this bill be introduced again in 1997, MSMA will oppose it.

Universal Health Care

Although support for a Canadian-style single-payor health care system has declined in Jefferson City, this bill's proponents always fight a good fight. Under this plan all Missourians would be guaranteed free health care. There would be one payor - the state - and physicians would have to negotiate with the state on all fees for services. MSMA will oppose this measure.

Statute of Limitations

MSMA again will pursue passage of a bill to prohibit a disciplinary proceeding against any licensed professional unless formal charges are filed within five years of the alleged violation. Several safeguards are built into the package to ensure that the various licensing agencies will always be able to protect the public from dangerous practitioners.

Acupuncture

The acupuncturists again will push legislation to grant them licensure in Missouri. Last session their campaign included free acupuncture therapy for legislators and Capitol staffers. They have managed to generate interest and sympathy for their cause, and MSMA will have its hands full trying to stop them.

Workers' Compensation

The business community has made workers' compensation reform one its highest priorities for 1997. MSMA will be monitoring their efforts to ensure that any new proposals are acceptable. Possible reforms being mentioned include Medicare's fee schedule for physicians' services and language that would allow the injured worker to choose a chiropractor for post-injury care.

Tobacco

Every year several tobacco-related measures are introduced. Some of these would strengthen anti-tobacco regulations, some would relax them. Last year the tobacco industry launched a major offensive that would have prohibited local governments from enacting ordinances to govern the sale, display, or distribution of tobacco products. We struggled desperately, but succeeded in repelling big tobacco. There is no reason to believe it won't be back in 1997.

Marijuana

We expect to see reintroduced a proposal to legalize the use of marijuana - the plant itself - for medicinal purposes. While MSMA does support carefully controlled scientific studies to evaluate its clinical efficacy, we do not support adding marijuana to the state's drug formulary.

Bicycle Helmets

MSMA again will support legislation to require all bicyclists to wear approved safety helmets. This proposal has gone down to defeat several times in the last few years.

Seatbelts in Pickups

Current law exempts pick-up trucks from the state's seatbelt law. MSMA again will support a measure that would mandate the use of seatbelts in all pick-ups except those used on farms.

Ban Fireworks Sales

MSMA supports passage of legislation to ban the sale, use, storage, and possession of bottle rocket fireworks in Missouri. In recent years Missouri's ophthalmologists have sponsored this legislation.

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Legislation and MSMA Policies Start With You

The process of creating legislation or policy supported by the Missouri State Medical Association begins with the ideas and needs of our members. The first step is stating those needs in the form of a resolution. Resolutions may be submitted by individuals, component medical societies or groups of MSMA members.

For a resolution to be included in the MSMA 1997 Annual Meeting Delegate Handbook, (April 10-13, Westin Crown Center, Kansas City), it must be received by the MSMA office by Feb. 24, 1997.

Submit your resolutions to:
MSMA ◆ 113 Madison ◆ P.O. Box 1028
Jefferson City, MO 65102
or fax to 573-636-8552.

Legislative Affairs Committee

Chair: Robert Miller, MD, *St. Louis*
David Barbe, MD, *Mountain Grove*
A. J. Campbell, MD, *Sedalia*
William Dorzab, MD, *Kansas City*
Frederick Hahn, MD, *Independence*
Mrs. Joan H'Doubler, *Springfield*
Deborah Jantsch, MD, *Kansas City*
Jerry Kennett, MD, *Columbia*
Norman Knowlton, III, MD, *Springfield*
Mrs. Becky Moore, *Joplin*
Charles Norland, MD, *St. Louis*
Daniel O'Sullivan, MD, *St. Louis*
Charles Porter, MD, *Kansas City*
Robert Schaaf, MD, *St. Joseph*
William Shell, MD, *Sikeston*
Robert Wankum, MD, *Jefferson City*
David Wilkinson, MD, *St. Louis*
Carol Williams, MD, *St. Louis*

Managed Care Reform in the Political Limelight

Reacting to a vast array of managed care reform bills pending at mid-session last winter, the Senate President Pro Tem declared his chamber overwhelmed and announced he would not allow the Senate to take action on any managed care bill. In return, he promised to appoint a special committee to meet during the summer to assess managed care in Missouri, evaluate its strengths and weaknesses, and recommend appropriate remedial legislation.

In fulfillment of that obligation, the Pro Tem and the Speaker of the House appointed the Joint Interim Committee on Managed Care, a bipartisan panel comprised of five senators and five representatives. The Joint Committee began its work in August with a series of public hearings held in Jefferson City. By the end of October the Committee had heard from some 200 witnesses who generated more than 2500 pages of transcripts and an additional 2000 pages of supporting documents.

More than 25 MSMA members travelled to Jefferson City - some of them more than once - to testify as patient advocates. Member physicians represented local medical societies from St. Louis, Kansas City, Boone County, Cole County, and the Franklin, Gasconade, and Warren Counties Medical Society. Several specialty societies were represented as well.

MSMA offered its Patient Fairness Act and reminded the committee that many of the complaints it has heard about managed care are addressed in that proposal.

Other physicians hammered away at managed care's weaknesses, criticizing its impact on quality of care. MSMA members detailed the dangers of such improper practices as gag clauses, unreasonable preauthorization requirements, limits on referrals, restrictive drug formularies, incentives to not provide care, and unfair discrimination against mental health patients.

The insurance industry was equally vocal. Its representatives advised the Joint Committee that the reported problems with managed care are anecdotal at best, and change is not warranted. The marketplace, they said, will provide any needful remedy.

In October the Committee distilled the countless hours of testimony into a list of twenty "discussion points." The major players were asked to sit again before the Committee and comment on the merits of each. MSMA not only offered further testimony, but provided model language to accomplish many of the recommended reforms.

On November 18, the Committee made public its final report, a twenty-two page document containing thirty-three specific recommendations. Those recommendations are published on pages 26-29. Happily, nearly every reform MSMA advocated was embraced by the Committee and incorporated into its report.

At the time of this writing the Joint Committee is at work transforming the recommendations into legislative language. Although final decisions are yet to be made, it is widely believed the Committee will incorporate the recommendations into one comprehensive managed care reform package to be introduced when the General Assembly convenes in January.

If that scenario plays out, the Joint Committee's managed care bill will be one of the top two or three major legislative proposals to come before the legislature in 1997. And it will be MSMA's highest priority.

The ground is fertile, and we are very excited at the prospects

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of passing this important initiative. But it won't come easy. The insurance industry and the business community will pitch a ferocious battle to stop this bill. And we must answer with equal ferocity.

Every physician must contact his or her senator and representative - on more than one occasion. A sample letter and writing instructions are printed on page 30. And calls and letters must pour into Jefferson City from your patients, the ultimate focus of this struggle. Don't be shy to ask for their assistance.

Keep this journal handy, and keep an eye on MSMA's weekly Legislative Report. We will keep you abreast of the news and provide thorough instructions on how to help. Let's make this medicine's finest hour! MoMed

Joint Interim Committee on Managed Care

Recommendations to the General Assembly

Recommendation (1)

The General Assembly should adopt legislation requiring the Department of Insurance to use network adequacy as a criteria for approval of certificates of authority to operate a managed care organization, and as a criteria for approval of any health care plan before it is marketed to enrollees. The criteria for network adequacy should be based on the National Association of Insurance Commissioners (NAIC) model legislation, and should take into account access to all hospitals, pharmacists and other classes of health care providers in the plan.

Recommendation (2)

The General Assembly should adopt legislation whereby individual physicians may apply to the Department of Health for a designation as an essential community provider. This designation shall be based upon criteria established by rule of the Department of Health. The Department of Insurance shall ensure that no managed care organization discriminates against essential community providers as designated by the Department of Health. Such discrimination may be grounds for the revocation of the managed care organization's certificate of authority.

Recommendation (3)

The General Assembly should enact legislation to ensure that those individuals who seek specialist care for a continuing medical condition can receive that care without obtaining prior approval from their primary care provider before each visit. In these specific cases where enrollees have a continuing medical condition, the managed care company shall not require enrollees to visit their primary care provider for that condition more frequently than once per year. This in no way shall prevent enrollees from seeking care from their primary care providers for the continuing medical condition or any other medical condition.

Recommendation (4)

The General Assembly should enact legislation to require managed care organizations to offer their enrollees the option of self-referral to plan approved dentists, chiropractors, optometrists, ophthalmologists, and ob/gyns for female enrollees, for health care options associated with those specialties. Managed care organizations may require these specialist care providers to notify the enrollee's primary care provider when the enrollee self-refers.

Recommendation (5)

The General Assembly should enact legislation that would require the Missouri Consolidated Health Care Plan to design and implement a pilot project to include all licensed health care providers in the Plan's Request for Proposals. (RFPs).

Recommendation (6)

The internal grievance process currently established by rule of the Department of Insurance should be formalized and placed in statute. The internal grievance process should be modified based on the NAIC model, and the process should be standardized across all managed care organizations operating in this state. The Department of Insurance should develop a standardized form for filing written grievances. Managed care organizations should be statutorily required to report all written grievances to the Department of Insurance.

Recommendation (7)

Managed care organizations should be required to disclose the grievance process, as well as the rights and responsibilities of the enrollee to file a grievance, in clear and simple terms to enrollees and in a manner approved by the Department of Insurance. The customer service numbers of the managed care organization and the Department of Insurance should be included in the customer handbooks and marketing materials provided to potential enrollees at the point of purchase.

Recommendation (8)

The General Assembly should enact legislation to require every managed care organization operating in this state to develop and maintain an approved internal appeals mechanism for de-selection decisions, when such de-selection occurs during the provider's contract year. All decisions to terminate the services of a provider should be made in writing, and should contain an explanation of why the provider is being deselected from the plan. Providers should have an opportunity to comply with the mandates of the organization before de-selection actually occurs. Providers should be notified of the intent to terminate their contracts 60 days prior to termination, and providers should be required to give 60 days' notice of their intent to cancel or terminate their contracts with managed care plans. Enrollees should be notified 30 days in advance by the managed care organization if the organization intends to deselect a provider or by the provider if the provider intends to voluntarily terminate the contract with the managed care organization. Providers should be given at least 30 days to review managed care contracts.

Recommendation (9)

The General Assembly should enact legislation to prohibit gag clauses in health care contracts. The Department of Insurance should not approve any managed care plan that contains gag or other clauses that may have the effect of limiting a provider's ability to discuss and recommend health care options with an enrollee.

Recommendation (10)

Capitation arrangements, with any subsequent amendments, should be disclosed to the Department of Insurance as part of the requirements for granting certificates of authority and annual plan approval. In all cases, these arrangements should be deemed proprietary information and not publicly disclosed. The Department of Insurance should not approve any capitation arrangement that may have the effect of limiting the quality of care enrollees receive. The Department of Insurance shall approve or disapprove of such arrangements within 30 days of filing.

Recommendation (11)

The General Assembly should enact legislation to require employers to open enrollment if the employer offers more than one health care plan or to allow employees to move to a point of service option if their health plan has such an option in all situations where enrollees lose their primary care provider, through de-selection, during the enrollees' contract period. The Department of Insurance should require all managed care organizations to disclose and make available to enrollees the date the contract expires for all providers in the plan.

Recommendation (12)

Provisions of law that provide for immunity for managed care companies from medical liability should be repealed.

Recommendation (13)

All managed care companies shall provide enrollees with a list of covered durable medical goods. Consumers should have an opportunity to appeal the inclusion of certain items as a durable good through the utilization appeal process.

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Continued from page 27

Recommendation (14)

The General Assembly should enact legislation to adopt the prudent layperson standard for emergency care, and statutorily define medical necessity.

Recommendation (15)

The General Assembly should enact legislation to require managed care organizations to issue confirmation numbers for all emergency or urgent care preauthorization decisions, and to prohibit retroactive denial of payment for those decisions. Preauthorization decisions should be made within 30 minutes or the decision is automatically deemed approved.

Recommendation (16)

The General Assembly should enact legislation to expand section 354.515 RSMo concerning the confidentiality of medical records in order to increase the protections afforded those seeking and receiving mental health treatment. All managed care organizations that offer mental health benefits shall be required to provide each enrollee two visits per year to a plan approved mental health professional without seeking prior approval from the enrollee's primary care provider.

Recommendation (17)

The General Assembly should enact legislation to require managed care organizations to charge equal deductibles and copayments for mental health and for physical health.

Recommendation (18)

The General Assembly should enact legislation to ensure that providers have the right to appeal for the inclusion of prescription drugs to the formulary. This should be part of the utilization review appeal.

Recommendation (19)

The General Assembly should enact legislation to require all managed care organizations operating in the state to contract only with mail order pharmacies that have registered with the State Board of Pharmacy and have been granted a license to fill prescriptions.

Recommendation (20)

Managed care companies should be statutorily prohibited from conferring benefits or placing restrictions on mail order pharmacies that they do not offer to on-site pharmacies. Companies who engage in these practices should be subject to unfair trade practices prosecution.

Recommendation (21)

The Board of Pharmacy should notify the Department of Insurance of any complaints associated with a pharmacy, including mail order pharmacies, that has a contractual arrangement with any insurance entity, including managed care organizations, operating in the state.

Recommendation (22)

The Department of Insurance should be given statutory authority to require all plans and marketing materials to be approved prior to their use. All plan and marketing materials should be printed in clear and understandable terms. The plans should have statements of the rights and responsibilities of the enrollee, the grievance and utilization appeals process, the hotline numbers of the plan and the hotline number of the Department of Insurance.

Recommendation (23)

The Department of Insurance should be given statutory authority to levy civil penalties and other sanctions against managed care organizations that do not comply with applicable provisions of law. Managed care organizations shall have the right to appeal any penalty or other sanction that may be levied against them.

Recommendation (24)

The Department of Insurance is strongly urged to require managed care companies to disclose enrollee satisfaction statistics at the point of purchase, including, but not limited to, medical loss ratios, turnaround times for pre-authorizations, rates of denial for utilization decisions, and preexisting condition limitations, among other items deemed by the Director to be in the public interest.

Recommendation (25)

The General Assembly should enact legislation to formalize and standardize the utilization review process across all managed care organizations operating in this state. Managed care organizations should be required to disclose the process in clear and simple terms to enrollees and the providers in charge of their care, as well as the rights and responsibilities of the enrollee to file a grievance. In addition, the customer service numbers of the managed care organization and the Department of Insurance should be included in the consumer handbooks that are provided to new and prospective enrollees at the point of enrollment of the plan.

Recommendation (26)

The Department of Insurance should ensure that providers are given a clear explanation of the utilization review process and an explanation of their responsibilities to the enrollee to appeal adverse utilization decisions. Plan publications distributed to providers should contain the telephone numbers of the hotline of the plan to file a grievance and to challenge a utilization decision, as well as the complaint hotline number of the Department of Insurance.

Recommendation (27)

The Department of Insurance should be given statutory authority to review adverse utilization decisions and compel managed care organizations to comply with the decisions reached by the Department or an entity it contracts with to make those decisions.

Recommendation (28)

The state of Missouri should statutorily prohibit retroactive denial of pre-authorizations.

Recommendation (29)

The Department of Insurance should require managed care organizations to keep track of the wait times associated with utilizations decisions, as well as the number of decisions denied as a proportion of the total number of decisions made.

Recommendation (30)

The General Assembly should enact legislation to ensure that providers have an opportunity as part of the utilization review process to appeal to other providers in the plan who are trained in the same specialty.

Recommendation (31)

The state of Missouri should statutorily require medical directors of managed care organizations to be licensed in this state to practice medicine.

Recommendation (32)

The Missouri Consolidated Health Care Plan should conduct a study of the actuarial soundness of permitting small businesses, including sole proprietorships, limited partnerships, and other corporate entities, in the Plan. The study shall include an examination of the insurers that are currently available to these small businesses. The study shall be completed no later than one year after September 1, 1997.

Recommendation (33)

The Director of the Department of Health should be granted statutory authority to require managed care organizations to submit health quality indicator data, based on the MOHIS standards. The Director shall have authority to revise these standards as needed by rule. The Director shall issue an annual report which compares managed care organizations and their performance on the health quality indicators. The Director of the Department of Insurance shall enforce sanctions against any managed care organization failing to comply with these reporting requirements. The Director of the Department of Health may require other health care entities to submit health quality indicator data. **MoMed**

Please write to your senators and representatives in Jefferson City expressing your support for managed care reform. A listing of State Senators and Representatives and a map of Legislative Districts is provided on pages 36-41.

Below is a sample letter you may use as a model. In your letter, please draw on personal experiences that demonstrate the need for this action.

Contacting Your Legislators

When considering various legislative proposals, lawmakers want to know the views of their constituents. They always are impressed when a physician takes time away from a busy schedule to call upon them.

No one knows more about health care than physicians. Legislators want to know your opinion, so tell them your thoughts.

You may want to visit your legislators in Jefferson City. Make an appointment to meet with them, or perhaps offer to take them to lunch or dinner.

Before you visit legislators let MSMA lobbyists brief you on the status of legislation. Your visit will be more effective with complete knowledge of the status of particular bills.

A Legislator's time often is limited, so let them know if you want to discuss a complicated subject matter that would take more time than a brief visit. Be sure to thank them for their time.

Stay in touch with your legislators. Let them know your interest is sincere and that they can contact you if they need more information on a medical issue.

Sample Letter in Support of Managed Care Reforms

Honorable __________
Missouri Senate
Senate Post Office
Jefferson City, MO 65101

OR

Honorable __________
Missouri House of Representatives
House Post Office
Jefferson City, MO 65101

Dear Senator or Representative __________:

I write to encourage you to support the work and recommendations of the Joint Interim Committee on Managed Care. The Joint Committee spent the summer and fall gathering information on managed care in Missouri, and in November filed a report of its findings.

The reforms recommended by the Joint Committee would provide patients across Missouri with several important protections, including the right to understand what services a plan covers, the right to talk freely with their physician about treatment options, the right to file a grievance and appeal adverse reimbursement decisions, and the right to have emergency care covered.

The legislation recommended by the Joint Committee creates reasonable and important safeguards to ensure that patients and their physicians - not insurance companies - control the care they receive.

I applaud the work of the Joint Committee and urge you to support this effort.

Sincerely,

MSMA's Key Contact Program

Your action in MSMA's Key Contact Program is good, basic citizenship.

The members of the Missouri State Medical Association are all constituents represented by elected officials at the local, state and federal levels of government. These legislators place great emphasis on what their most active constituents have to say, for it is these constituents who vote either to help re-elect them to another term of office or elect someone else to take their job.

When constituent involvement in the political process is applied on legislative issues, it is described as "grassroots" lobbying. Grassroots lobbying on legislative issues is critically important when MSMA wants to pass, amend, or defeat various proposals. To enhance its government relations effort through grassroots activity, MSMA has created the ***Key Contact Program.***

Activities in the ***Key Contact Program*** are based on two central premises. First, government actions have their greatest impact at the community level. As such, local constituent pressures can be exerted to help influence how a legislator votes.

Second, government actions and activities have become so important to the medical community that the responsibility for legislative effectiveness must in part reside with physicians - not just with your MSMA lobbyists. While MSMA staff plays a fundamental role in the process, MSMA needs a broader base of political support to be more credible and effective.

Traditionally, MSMA members have been called on to write their lawmakers concerning government relations problems. However, our political needs now require participation that is more than just an occasional, informal effort. What is required is a systematic approach: MSMA's ***Key Contact Program.***

MSMA's ***Key Contact Program*** matches lawmakers with physicians from their districts who will keep in touch on legislative issues. That means each senator and representative will have at least one, and hopefully dozens of physicians in their district willing to take the time to call or write whenever medical issues arise. MSMA staff keeps its Key Contacts informed and engages the network when critical votes are expected or when certain lawmakers need to hear from a physician in their district.

The ***Key Contact Program*** is strictly nonpartisan. It is information as well as action oriented. It is good, basic citizenship. It is taking an active role in the government process, getting to know your elected representatives and making your views known to them. The ***Key Contact Program*** also will help promote the interest of all physicians, their families, and patients with government officials.

☑ Goals of the MSMA's Key Contact Program

☑ To promote the interests of your profession, your practice, and your patients through contacts with lawmakers;

☑ To better understand issues affecting medicine and be able to explain organized medicine's position to elected officials on a constituent basis;

☑ To inform other physicians of the impact of government legislation and regulation on their business and personal lives;

☑ To help legislators and other government officials understand the impact proposed legislation and regulations have on the health care delivery system.

☑ To motivate physicians, their patients, and their families to become involved in the political process.

○ Key Contact Responsibilities

○ To carry out the goals of the program, physicians serving as Key Contacts are asked to assume the following responsibilities:

○ To represent the views of medicine to assigned federal and state elected officials in whose district you live;

○ To develop personal, constituent relationships with your assigned elected officials and other government officials based on mutual respect and trust;

○ To be aware of pending legislation at the state and federal levels and, with the assistance of MSMA staff, be prepared to discuss its impact on medicine, your patients, and the local community;

○ To help build community understanding and support for MSMA's position on issues of major concern;

○ To assist with the implementation of any future grassroots program activities that involve other physicians and other constituent support groups in the community.

Most of the people in this house have never practiced medicine.

Become a Key Contact for the 1997 Legislative Session!

Your Involvement is Key to our Success!

The Key Contact Program has been very successful, and our Key Contacts have enjoyed it immensely! We hope you'll give it a try. It takes no special training. We'll guide you along the way. Just copy and fill out the form below and return it to **MSMA, P.O. Box 1028, Jefferson City, MO 65102, or Fax: 573-636-8552.**

My state representative is: ______________________________

My state senator is: ______________________________

My name: ______________________________

Address: ______________________________

Phone: ____________________ **Fax:** ____________________

✂ **Cut Here and Return!**

Make an Impact! Support MMPAC!

Consider the dramatic changes proposed in Medicaid and Medicare.

Consider the relentless encroachment of managed care.

Consider proposed reforms in our medical malpractice laws.

Government has become an integral part of the practice of medicine. Virtually every medical decision made will be impacted by the health care policy decisions being made by lawmakers and bureaucrats.

The political arena is crowded with special interest groups and many of these groups do not have medicine's best interest in mind. As each interest speaks out on its own behalf, only a unified force made up of physicians and their spouses can best represent the medical community and the patient.

The Missouri Medical Political Action Committee - MMPAC -works on behalf of the entire medical profession, enabling us to speak as one powerful, amplified voice. The Association's bipartisan political action committee works with elected officials to make sure they understand every aspect of health care legislation.

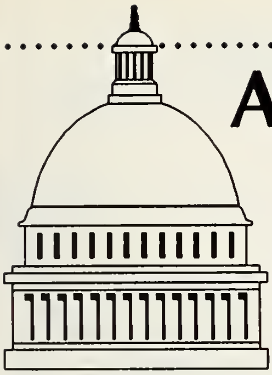
MMPAC contributions support candidates who support the legislative goals of physicians. Candidates are selected based on recommendations from MMPAC members and local districts.

Your participation in MMPAC offers you an effective means by which to become involved in the political process and expand the influence of the medical community in the complex political world.

Your MMPAC contribution is an investment - in the medical profession, in the future of our health care system, and in the future of our many patients.

Please help us advance the high standards and practices of the medical profession.
Please make a contribution of $100 (regular membership)
or $250 (SuperPac membership) to MMPAC today.
Send personal checks only, payable to:
MMPAC, P.O. Box 1402, Jefferson City, MO 65102.

Every Member Benefits From MMPAC's Success!



Alliance Day at the Legislature

March 4 & 5, 1997

Alliance Day at the Legislature is an opportunity for physicians and their spouses to discuss issues with their elected officials. This day is well established at the Capitol and many legislators attend. *Spouses are not only welcome to join us both days -they are encouraged.*

Tuesday, March 4

Noon:	Finance & Budget Committee Meeting, Capitol Plaza Hotel, Park Place Restaurant.
1:00 p.m	Meet in Hotel Lobby; deliver apple invitations to legislators.
3:00 p.m.	MSMAA Board Meeting, St. Mary's Health Center.
4:30 p.m.	Legislative Workshop; presented by Jean Wankum, AMAA Legislative Committee.
5:30 p.m.	Shuttle back to Hotel from St. Mary's.
6:45 p.m.	Carpool to Jefferson City Country Club.
7:00 p.m.	Cocktails/Dinner at Jefferson City Country Club (no host bar). MSMA lobbyist Tom Holloway will discuss current legislative issues.

Wednesday, March 5

7:30 a.m.	Meet at the Capitol Building, Rooms 3 & 4, lower level.
8:00 a.m.	Legislators will begin to visit. Coffee & rolls provided. You bring the conversation.
10:00 a.m.	Observe sessions in the House & Senate or visit your legislator's office.
11:00 a.m.	Luncheon/whole house tour at Governor's Mansion.

Event Fees:

"Alliance Day at the Legislature" fee:	$22.50, includes dinner at the Country Club.
"Governor's Mansion Luncheon" fee:	$18.00
"Total Package Registration" fee:	$40.50

REGISTER SOON!

Event Deadline is February 17, 1997! Seating is limited to sixty for Governor's Mansion.

Name ________________________

Address ________________________

City / Zip ________________________

County Society/Alliance ________________________

List names of legislators you will personally invite:

____

____

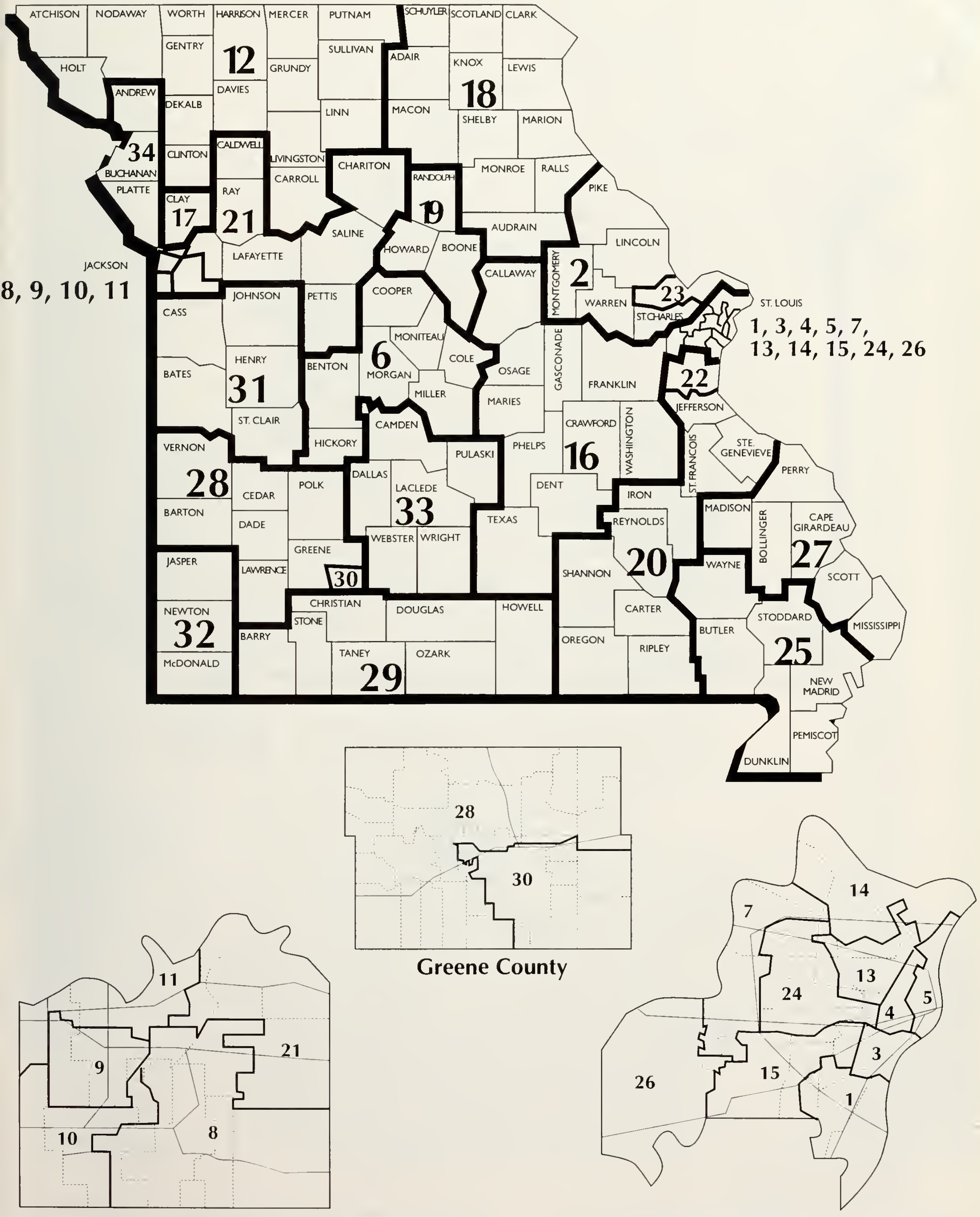
Please complete form and send with appropriate fee payable to MSMAA, to Melinda Kimlinger, 2637 Kenwood, Jefferson City, MO 65109. Call her at 573-635-1632 or fax registration at 573-636-5881.

Please Note: A block of rooms has been reserved for MSMAA members. To reserve hotel accomodations at the Capitol Plaza Hotel, call (573)635-1234 by February 11, 1997. After this date, rooms will be on sale to the public.

Missouri Senate - 89th General Assembly First Regular Session

SENATOR	DISTRICT	ADDRESS & PHONE NO.		ROOM NO.
Banks, J. B. (Jet)	**5**	1442A North Grand, St. Louis, MO 63106; 314/361-3800	**751-4650**	**319**
Bentley, Roseann	**30**	1500 E. Meadowmere, Springfield, MO 65804; 417/865-5160	**751-4145**	**421**
Caskey, Harold L.	**31**	P.O. Box 45, Butler, MO 64730; 816/679-4162	**751-4116**	**320**
Childers, Doyle	**29**	P.O. Box 127, Reeds Spring, MO 65737; 417/272-8281	**751-2058**	**425**
Clay Jr., William L.	**4**	6136 Washington Ave., St. Louis, MO 63112; 314/535-3212	**751-2229**	**429**
Curls, Phil B.	**9**	3832 Myrtle, Kansas City, MO 64128; 816/241-1200	**751-2400**	**221**
DePasco, Ronnie	**11**	925 Cleveland, Kansas City, MO 64127; 816/231-2515	**751-3074**	**321**
Ehlmann, Steve	**23**	820 S. Main St., Suite 302, St. Charles, MO 63301; 314/949-2323	**751-8635**	**434**
Flotron, Frances E.	**7**	14 Arrowhead, Chesterfield, MO 63017; 314/434-2115	**751-2371**	**331**
Goode, Wayne	**13**	7717 Natural Bridge Rd., Normandy, MO 63121; 314/385-9010	**751-2420**	**334**
Graves, Sam	**12**	Rt. 2, Box 5, Tarkio, MO 64491; 816/736-4751	**751-3271**	**225**
House, Ted	**2**	3077 Winding River Dr., St. Charles, MO 63303; 314/946-0077	**751-8437**	**227**
Howard, J. T.	**25**	P.O. Box 279, Dexter, MO 63841; 573/624-8778	**751-3301**	**428A**
Jacob, Ken	**19**	4810 St. Charles Rd, Columbia, MO 65201; 573/442-2882	**751-2131**	**420A**
Johnson, Sidney	**34**	9970 Johnson Rd., Agency, MO 64401; 816/253-9248	**751-3750**	**332**
Kenney, Bill	**8**	2410 S.W. Hook Rd., Lee's Summit, MO 64082; 816/524-7272	**751-7050**	**328**
Kinder, Peter	**27**	635 N.W. End Blvd., Cape Girardeau, MO 63701; 573/335-6611	**751-2455**	**431**
Klarich, David	**26**	34 Roland Ave., Ballwin, MO 63021; 314/230-8116	**751-1073**	**427**
Lybyer, Mike	**16**	12743 Hwy. 38, Huggins, MO 65484; 417/967-3227	**751-2601**	**333**
Mathewson, James L.	**21**	142 South Limit, Sedalia, MO 65301-3655; 816/826-7815	**751-4771**	**323**
Maxwell, Joe	**18**	210 E. Love, Mexico, MO 65265	**751-4200**	**219**
McKenna, William P.	**22**	6969 Dippel Lane, Barnhart, MO 63012; 314/464-5684	**751-2504**	**326**
Mueller, Walt	**15**	12325 Manchester Rd., St. Louis, MO 63131; 314/966-2526	**751-3838**	**330**
Quick, Edward E.	**17**	13004 A. Highway, Liberty, MO 64068; 816/454-1078	**751-4524**	**331A**
Rohrbach, Larry	**6**	HCR 60, Box 12, California, MO 65018; 573/796-3708	**751-2780**	**433**
Russell, John T.	**33**	P.O. Box 93, Lebanon, MO 65536; 417/532-6050	**751-4166**	**419**
Schneider, John D.	**14**	3520 Tremont Dr., Florrisant, MO 63033; 314/421-2762	**751-4106**	**422**
Scott, John E.	**3**	3761 Bates, St. Louis, MO 63116; 314/481-6864	**751-3644**	**416**
Sims, Betty	**24**	18 Ladue Manor, St. Louis, MO 63124; 314/994-0793	**751-7147**	**226**
Singleton, Marvin	**32**	3401 McIntosh Circle, Joplin, MO 64804; 417/781-2040	**751-2306**	**426**
Staples, Danny	**20**	HCR 3, Box 18, Eminence, MO 65466; 573/756-5592	**751-3534**	**418**
Westfall, Morris	**28**	4671 Hwy. H, Halfway, MO 65663; 417/326-5156	**751-3645**	**220**
Wiggins, Harry	**10**	7817 Terrace, Kansas City, MO 64114; 816/444-5718	**751-2788**	**423**
Yeckel, Anita	**1**	8819 Gladlea, St. Louis, MO 63127; 314/849-4946	**751-2887**	**329**

Missouri Senate Districts


ATCHISON
NODAWAY
WORTH
HARRISON
MERCER
PUTNAM
SCHUYLER
SCOTLAND
CLARK
HOLT
GENTRY
12
GRUNDY
SULLIVAN
ADAIR
KNOX
LEWIS
18
ANDREW
DEKALB
DAVIES
LINN
MACON
SHELBY
MARION
34
BUCHANAN
CLINTON
CALDWELL
LIVINGSTON
CHARITON
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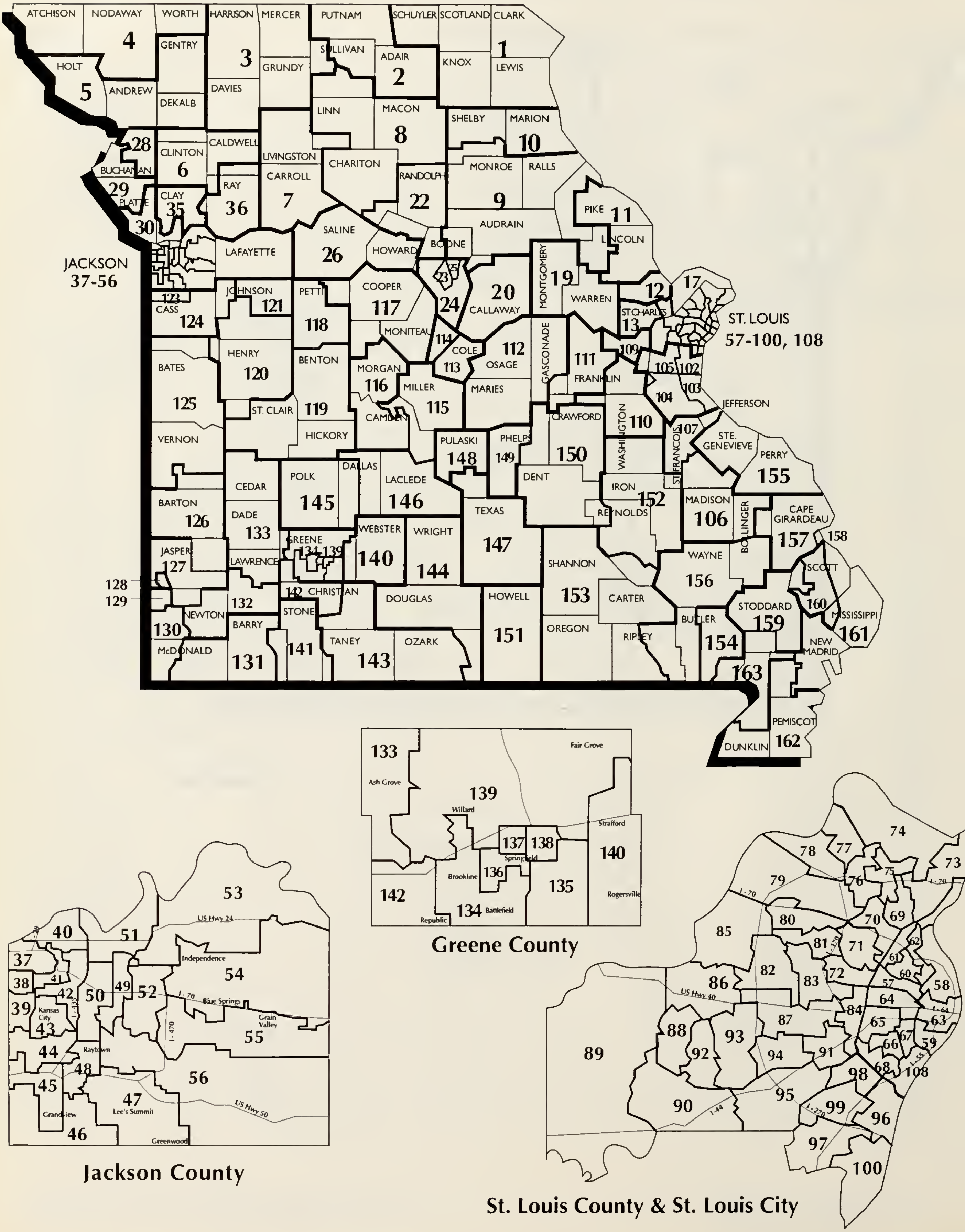
Jackson County

Greene County

St. Louis County & St. Louis City

Missouri House Districts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Greene County

Jackson County

St. Louis County & St. Louis City

Missouri House of Representatives - 89th General Assembly
First Regular Session

REPRESENTATIVES	DISTRICT	ADDRESS & PHONE NO.		ROOM
Akin, W. Todd	86	305 Conway Hill Rd., St. Louis, MO 63141; 314/434-7948	751-1186	115E
Alter, Bill	90	1800 Gravois, High Ridge, MO 63049; 314/677-8191	751-2732	201C
Auer, Ron	59	3120 S. Compton, St. Louis, MO 63118; 314/453-1894	751-4567	411-2
Backer, Gracia Y.	20	2859 Rt. TT, New Bloomfield, MO 65063; 573/295-6190	751-2070	309
Ballard, Charles	140	Rt. 4, Box 3450, Marshfield, MO 65706; 417/859-6454	751-9809	135BB
Barnett, Rex	4	708 West Lincoln, Maryville, MO 64468; 816/582-4014	751-9465	116A
Barry, Joan	100	5050 Lampglow Ct., St. Louis, MO 63129; 314/487-1558	751-9804	305B
Bartelsmeyer, Linda	132	1668 Oak Drive, Aurora, MO 65605; 417/678-5822	751-9806	115J
Bauer, Tom	65	1936 Forest Avenue, St. Louis, MO 63139; 314/644-5058	751-4220	409B
Bennett, Jon	15	1268 Heritage Court, St. Charles, MO 63303; 314/440-2300	751-9627	109E
Berkstresser, Judy	141	RR#1 Box 349B, Crane, MO 65633; 417/723-8864	751-1503	101K
Bland, Mary	43	1632 Bushman, Kansas City, MO 64110; 816/233-4441	751-2770	314
Boatright, Matt	118	29612 Pony Path Road, Sedalia, MO 65301; 816/826-1880	751-9774	105H
Bonner, Dennis	51	947 S. Washington, Independence, MO 64050; 816/842-0707	751-5701	409A
Boucher, Bill	48	11320 Sunnyslope Dr., Kansas City, MO 64134; 816/966-8576	751-7335	300B
Bray, Joan	84	7120 Washington Ave., St. Louis, MO 63130; 314/725-7862	751-2514	412A
Broach, David W.	102	2007 Ronnies Dr., Arnold, MO 63010; 314/464-0600	751-3264	105G
Burton, Gary L.	128	801 Fir Road, Joplin, MO 64836; 417/623-6400	751-7082	201G
Campbell, Marsha	39	445 Westover Road, Kansas City, MO 64113; 816/363-8474	751-4485	405B
Carter, Paula J.	61	5936 Summit, St. Louis, MO 63147; 314/382-2900	751-6500	235
Champion, Norma	134	3609 S. Broadway, Springfield, MO 65807; 417/865-2815	751-2583	105A
Chrismer, Rich	16	25 Barkwood Trails, St. Peters, MO 63376; 314/441-6219	751-2949	101I
Cierpiot, Connie J.	52	15403 E. 44th, Independence, MO 64055; 816/373-8935	751-9759	109D
Clayton, Robert	10	2827 Pleasant St., Hannibal, MO 63401; 573/221-7333	751-9614	114A
Cooper, Bonnie Sue	32	413 NW 58th St., Kansas City, MO 64118; 816/453-4419	751-2134	203B
Copeland, Gene	161	30 Greenbriar Dr., New Madrid, MO 63869; 573/751-4560	751-4560	302A
Crawford, Larry	117	RR#2, Box 95, Centertown, MO 65023; 573/796-2071	751-2134	115I
Crump, Wayne F.	152	606 Pine St., Potosi, MO 63664; 573/751-2101	751-2101	310
Daniel, Lloyd	42	4437 Benton Blvd., Kansas City, MO 64130; 816/292-2835	751-9758	300A
Daniels, Fletcher	41	3537 Askew, Kansas City, MO 64128; 816/924-1513	751-3158	315
Davis, D. J.	122	204 N. Connor, Odessa, MO 64076; 816/230-5224	751-1500	406A
Davis, Dorathea	63	3305 Lemp, St. Louis, MO 63104; 314/773-4770	751-2606	304A
Days, Rita D.	71	3083 Bellerive Dr., St. Louis, MO 63121; 314/385-0447	751-4468	313A
Dolan, Jon	13	902 Bridlespur Lane, Lake St. Lous, MO 63367; 314/947-1515	751-4964	135BC
Donovan, Laurie B.	74	#7 Ipswich Ct., Florissant, MO 63033; 314/741-1443	751-2135	200B
Dougherty, Patrick	67	4031 Parker Ave., MO 63116; 314/772-1948	751-3599	313C
Edwards-Pavia, Marilyn	105	8375 Byrnesville Rd., House Springs, MO 63051; 314/274-2165	751-4343	116-4
Elliott, T. Mark	127	208 Fairway, Carl Junction, MO 64834; 417/673-8464	751-5458	135AA
Enz, Catherine S.	99	10018 St. Simon Ct., St. Louis, MO 63123; 314/435-0220	751-9768	109I
Evans, Brent	92	4 Westbrooke Terr Ct., Manchester, MO 63021; 314/878-7887	751-9765	105J
Farmer, Nancy	64	5843 Waterman, St. Louis, MO 63112; 314/721-3083	751-1400	407A
Farnen, Ted	21	13 Wonneman Circle, Mexico, MO 65265; 573-581-1000	751-9458	236B
Fitzwater, Rodger	36	RR#2, Box 206, Norborne, MO 64668; 816/484-3500	751-9757	400CA
Foley, James Michael	81	3274 Adie Rd., St. Ann, MO 63074; 314/426-7675	751-0855	408A
Ford, Louis H.	58	3229 North 20th St., St. Louis, MO 63107; 314/241-1626	751-2383	402B
Foster, Bill I.	156	RR#9, Box 252-1, Poplar Bluff, MO 63901; 573/785-3586	751-3859	116-1
Franklin, Richard	53	18005 Cheyenne, Independence, MO 64056; 816/796-3088	751-6535	404A
Fritts, Charlie	125	RFD#3, Box 466, Butler, MO 64730; 816/679-5624	751-2033	235BA
Froelker, James V.	111	7437 Highway H, Gerald, MO 63037; 573/925-4142	751-6668	135BA
Gaskill, Sam	131	HCR 79, Box 345, Washburn, MO 65772; 417/435-2304	751-9801	102BB
Gaston, Doug	147	P.O. Box 279, Houston, MO 65483; 417/967-4070	751-1641	105I

Gaw, Steve	**22**	P.O. Box 314, Moberly, MO 65270; 816/263-9000	**751-2700**	**308**
Gibbons, Michael R.	**94**	651 Pearl Ave., Kirkwood, MO 63122; 314/821-4616	**751-2853**	**106B**
Goward, Russell	**60**	5000 Tyus Ct., St. Louis, MO 63115; 314/381-6808	**751-2704**	**205**
Graham, Chuck	**24**	102 W. Green Meadows, Columbia, MO 65203; 573/442-0427	**751-2162**	**111**
Graham, Jim	**106**	Rt. 1, Box 145, Fredericktown, MO 63645; 573/783-7707	**751-3455**	**105B**
Gratz, William (Bill)	**113**	2315 Rt. M, Jefferson City, MO 65101; 573/635-4168	**751-0665**	**206C**
Green, Timothy P.	**73**	617 Science Hill, St. Louis, MO 63137; 314/869-9376	**751-6845**	**408A**
Griesheimer, John E.	**109**	33 Oxford Dr., Washington, MO 63090; 314/583-8000	**751-3678**	**106A**
Gross, Charles	**18**	3019 Westborough Ct., St. Charles, MO 63301; 314/947-7893	**751-1141**	**201D**
Gunn, Russell	**70**	6723 Maryellen, Northwoods, MO 63121; 314/382-1331	**751-4726**	**135**
Hagan-Harrell, Mary	**75**	100 Florwood Ct., Ferguson, MO 63135; 314/521-5555	**751-5836**	**316**
Hall, Glenn	**56**	10506 S. Perdue Rd., Grain Valley, MO 64029; 816/524-8111	**751-1464**	**203C**
Hand, Raymond W. (Bill)	**87**	545 Gascony Way, Warson Woods, MO 63122; 314/821-2040	**751-8510**	**109B**
Harlan, Tim	**23**	511 S. Glenwood Ave., Columbia, MO 65203; 573/874-2402	**751-9753**	**400CC**
Hartzler, Ed	**123**	303 Manor Ct., Belton, MO 64012; 816/331-0090	**751-2175**	**101F**
Hartzler, Vicky	**124**	22804 E. 299th St., Harrisonville, MO 64701; 816/884-5297	**751-9780**	**109F**
Heckemeyer, Joe	**160**	510 N. Main, Sikeston, MO 63801; 573/471-0550	**751-9829**	**415B**
Hegeman, Daniel J.	**5**	18739 County Rd. 294, Cosby, MO 64436; 816/662-2645	**751-0246**	**101D**
Hendrickson, Carl	**97**	4661 Markton Dr., St. Louis, MO 63128; 314/554-3183	**751-9766**	**101G**
Hickey, John	**80**	11743 Laux, Bridgeton, MO 63044; 314/298-8370	**751-4670**	**317B**
Hohulin, Martin (Bubs)	**126**	360 NW 20th Rd., Lamar, MO 64759; 800/878-7126	**751-2165**	**135AB**
Holand, Roy	**135**	1840 E. Vincent, Springfield, MO 65804; 417/885-7110	**751-2210**	**103BA**
Katherine Hollingsworth	**101**	1129 Westward Trails, Imperial, MO 63052; 314/342-4455	**751-1311**	**110B**
Hoppe, Thomas	**46**	12316 Charlotte, Kansas City, MO 64146; 816/561-2067	**751-9469**	**403A**
Hosmer, Craig	**138**	657 S. Weller, Springfield, MO 65802; 417/869-0581	**751-9474**	**207A**
Howerton, Jim	**120**	535 NW 1250, Chilhowee, MO 64733; 816/678-3331	**751-1484**	**105E**
Johnson, Mitchell (Rocky)	**107**	#4 Bradley Court, Desloge, MO 63601; 573/431-7283	**751-2317**	**200BC**
Kasten, Mary C.	**158**	1209 Sailor Circle, Cape Girardeau, MO 63701; 573/334-3111	**751-2459**	**101C**
Kauffman, Sandy	**45**	620 E. 90th Terr, Kansas City, MO 64131; 816/333-3826	**751-5543**	**115A**
Kelley, Pat	**47**	3924 SW Windsong Dr., Lee's Summit, MO 64082; 816/254-5116	**751-1456**	**109A**
Kelly, Glenda	**27**	3415 N. 3rd St., St. Joseph, MO 64505; 816/233-2614	**751-9755**	**130DC**
Kennedy, Harry	**66**	4959 Sutherland, St. Lous, MO 63109; 314/481-5857	**751-2126**	**406B**
Kissell, Don	**17**	408 Sutters Mill, St. Peters, MO 63376; 314/990-9099	**751-9628**	**410A**
Koller, Don	**153**	P.O. Box 135, Summersville, MO 65571; 417/932-4064	**751-2112**	**413A**
Kreider, Jim	**142**	P.O. Box 1980, Nixa, MO 65714; 417/443-3006	**751-2956**	**301**
Lakin, Scott	**33**	3700 NE 49th Terr, Kansas City, MO 64119; 913/338-2525	**751-6600**	**206B**
Lawson, Maurice	**29**	4105 Christy Lane, St. Joseph, MO 64504; 816/271-1454	**751-9460**	**130DA**
Leake, Sam	**9**	RR#2, Box 61A, Laddonia, MO 63352; 573/373-5685	**751-7852**	**404B**
Legan, Kenneth	**145**	1901 E. 487th Rd., Halfway, MO 65663; 417/445-2241	**751-3819**	**200A**
Levin, David	**82**	11208 Sherwood Oak Ct., St. Louis, MO 63146; 314/432-6502	**751-9762**	**116-3**
Liese, Chris	**85**	1948A Marine Terr Dr., St. Louis, MO 63146; 314/878-4787	**751-1832**	**114B**
Linton, William C.	**89**	17339 Cougar Trail, Grover, MO 63040; 314/458-0736	**751-1247**	**201B**
Lograsso, Don	**54**	404 Stonewall Drive, Blue Springs, MO 64014; 816/228-7551	**751-1487**	**107**
Long, Elizabeth L.	**146**	22975 Oneida Drive, Lebanon, MO 65536; 417/532-6946	**751-4451**	**201A**
Loudon, John	**88**	221 Pleasant Grove Ln., Ballwin, MO 63011; 314/623-6012	**751-9763**	**115G**
Luetkenhaus, Bill	**12**	742 Hancock Rd., Wentzville, MO 63385; 314/327-6539	**751-2176**	**233A**
Lumpe, Sheila	**72**	6908 Amherst, University City, MO 63130; 314/863-4918	**751-4265**	**306**
Marble, Gary	**130**	12083 Mallard Drive, Neosho, MO 64850; 417/451-1455	**751-9781**	**135AC**
May, Brian H.	**108**	5816 Pennsylvania, St. Louis, MO 63111; 314/621-4500	**751-0438**	**112**
Mays, Carol Jean	**50**	3603 Hedges, Independence, MO 64052; 816/252-0900	**751-7639**	**206A**
McBride, Jerry E.	**149**	P.O. Box 292, Edgar Springs, MO 65462; 573/435-6639	**751-4950**	**411B**
McClelland, Emmy L.	**91**	455 Pasadena, Webster Groves, MO 63119; 314/962-1796	**751-1285**	**115C**
McLuckie, Steve	**44**	9738 Shepards Dr., Kansas City, MO 64131; 816/756-1818	**751-2437**	**412B**
Miller, Ronnie	**133**	623 Morgan Drive, P.O. Box 5, Stockton, MO 65785; 417/226-3343	**751-1347**	**115H**
Monaco, Ralph	**49**	7013 Englewood, Raytown, MO 64133; 816/333-9600	**751-9851**	**405A**
Murphy, Jim	**95**	9314 Cordoba Lane, Crestwood, MO 63126; 314/849-5914	**751-2150**	**109C**
Murray, Dana L.	**69**	2422 Mary, St. Louis, MO 63136; 314/388-0417	**751-5538**	**313B**

Naeger, Patrick A.	**155**	14 Richardet, Perryville, MO 63775; 573/547-4526	**751-9812**	**103BC**
Nordwald, Charles	**19**	#20 Hawthorne, Warrenton, MO 63383; 314/338-4404	**751-2689**	**105D**
O'Connor, Patrick	**79**	4413 Claremont, Bridgeton, MO 63044; 314/298-7418	**751-2726**	**317A**
O'Toole, James P.	**68**	5445 Finkman, St. Louis, MO 63109; 314/353-0864	**751-2251**	**303B**
Ostmann, Cindy	**14**	445 Knaust Rd., St. Peters, MO 63376; 314/240-5376	**751-2250**	**115F**
Overschmidt, Francis S.	**110**	151 N. Outer Rd., Union, MO 63084; 314/583-5591	**751-2398**	**403B**
Parker, Kelly	**150**	#3 Amber Trail, Salem, MO 65560; 573/729-3127	**751-2108**	**134**
Patek, Jewell	**7**	P.O. Box 55, Chillicothe, MO 64601; 816/752-7745	**751-2917**	**116-2**
Pouche, Fred	**30**	10015 N.W. Mirror Lake Dr., Kansas City, MO 64152; 816/741-6537	**751-9756**	**116-5**
Prost, Donald	**162**	1801 Marilyn Dr., Caruthersville, MO 63830; 573/333-2130	**751-2264**	**233B**
Pryor, Charles R.	**116**	410 W. Newton, Versailles, MO 65084; 573/378-4082	**751-4119**	**101J**
Purgason, Chuck	**151**	2680 Rd. 7360, Caulfield, MO 65626; 417/284-3332	**751-1882**	**103BB**
Ransdall, Bill	**148**	503 Wildwood Lane, Waynesville, MO 65583; 573/341-3838	**751-1727**	**410B**
Reinhart, Annie	**34**	617 Lancelot, Liberty, MO 64068; 816/781-2919	**751-1218**	**116A**
Relford, Randall	**6**	504 Country Club Square, Cameron, MO 64429; 816/632-7414	**751-9819**	**235BB**
Reynolds, David L.	**77**	1325 Verlene Dr., Florissant, MO 63031; 314/839-1111	**751-9761**	**201BA**
Richardson, Mark L.	**154**	3411 Normandy Rd., Poplar Bluff, MO 63901; 573/686-3342	**751-4039**	**204**
Ridgeway, Luann	**35**	19405 Platte Co. Line Rd., Smithville, MO 64089; 816/532-0032	**751-2238**	**105F**
Rizzo, Henry C.	**40**	575 Harrison, Kansas City, MO 64106; 816/833-4700	**751-3310**	**413B**
Robirds, Estel	**143**	Rt. 2, Box 2919, Theodosia, MO 65761; 417/273-4777	**751-2042**	**102BA**
Ross, Carson	**55**	3305 Park Ln, Blue Springs, MO 64015; 816/274-4435	**751-8636**	**105C**
Sallee, Mary Lou	**144**	914 N.W. 9th St., Ava, MO 65608; 417/683-4286	**751-2205**	**101H**
Scheve, May	**98**	6612 Gramond, St. Louis, MO 63123; 314/849-3704	**751-9472**	**401A**
Schilling, Mike	**136**	1027 S. New, Springfield, MO 65807; 417/862-2272	**751-2652**	**234**
Schwab, David	**157**	2835 County Road 435, Jackson, MO 63755; 573243-5966	**751-6662**	**203A**
Scott, Delbert	**119**	P.O. Box 147, 700 E. 7th, Lowry City, MO 64763; 417/644-2244	**751-8793**	**201CA**
Secrest, Patricia K.	**93**	723 Country Heights Ct., Manchester, MO 63021; 314/821-2040	**751-4392**	**101A**
Seigfried, James	**26**	1560 The Oaks, Marshall, MO 65340; 816/886/6957	**751-2204**	**130DB**
Shear, Sue	**83**	200 S. Brentwood, Clayton, MO 63105; 314/863-0975	**751-4163**	**302B**
Sheldon, Norman E.	**104**	5201 State Rd. H, De Soto, MO 63020; 314/586-2192	**751-7735**	**411A**
Shelton, O. L.	**57**	1803A Cora, St. Louis, MO 63113; 314/533-1322	**751-2198**	**407B**
Shields, Charles W.	**28**	47 S.E. Erin Ct., St. Joseph, MO 64507; 816/233-8090	**751-9476**	**101E**
Skaggs, Bill	**31**	3613 North Park, Kansas City, MO 64116; 816/452-5328	**751-2199**	**414**
Smith, Philip	**11**	215 N. Third, Louisiana, MO 63353; 573/754-4577	**751-9459**	**207B**
Steen, Don	**115**	Rt. 3, Box 302, Eldon, MO 65026; 573/392-5992	**751-2077**	**109G**
Stokan, Lana	**76**	1589 Knollway Dr., Florrissant, MO 63135; 314/838-6497	**751-9760**	**305A**
Stoll, Steve	**103**	716 Richard Ave., Festus, MO 63028; 314/933-0233	**751-1492**	**305B**
Stroker, Carol	**78**	527 Holiday Ave., Hazelwood, MO 63042; 314/895-1144	**751-1200**	**305B**
Summers, Don	**2**	Rt. 4, Box 209, Unionville, MO 63565; 816/947-2283	**751-0224**	**101B**
Surface, Chuck	**129**	2401 W. 29th, Joplin, MO 64804; 417/624-5695	**751-2173**	**201F**
Tate, Phil	**3**	901 West Grand, Gallatin, MO 64640; 816/663-3710	**751-1415**	**311**
Thomason, Larry	**163**	P.O. Box 523, Kennett, MO 63857; 573/888-4100	**751-8591**	**412C**
Thompson, Vernon	**37**	1330 Park, Kansas City, MO 64127; 816/474-1151	**751-1309**	**312**
Townley, Merrill	**112**	RR#1, Chamois, MO 65024; 314/763-5795	**751-1344**	**109H**
Treadway, Joseph L.	**96**	1456 Telegraph, Lemay, MO 63125; 314/878-4200	**751-2315**	**401B**
Troupe, Charles Quincy	**62**	5338 Claxton, St. Louis, MO 63120; 314/383-3814	**751-2851**	**113**
Van Zandt, Tim	**38**	4637 Charlotte, Kansas City, MO 64110; 493/931-9462	**751-5282**	**400CB**
Vogel, Carl	**114**	311 Constitution, Jefferson City, MO 65109; 573/636-6165	**751-2076**	**115B**
Wannenmacher, Philip P.	**139**	1366 E. Smith, Springfield, MO 65803; 417/833-0854	**751-2948**	**201E**
Wiggins, Gary	**8**	30093 St. Hwy P, New Cambria, MO 63558; 816/226-5619	**751-1042**	**303A**
Williams, Deleta	**121**	713 Tyler, Warrensburg, MO 64093; 816/429-6893	**751-2272**	**236A**
Williams, Marilyn A.	**159**	108663 County Rd. 442, Dudley, MO 63936; 573/624-8333	**751-0728**	**400**
Wilson, Vicky	**25**	3201 Blackberry Lane, Columbia, MO 65201; 573/882-5859	**751-1169**	**110A**
Wooten, Chuck	**137**	2146 N. Broadway, Springfield MO 65803; 417/864-4328	**751-6562**	**115D**

Techniques for Political Effectiveness

You have an opportunity, both as a representative of the medical community and as a citizen, to establish continuous, effective communications with your lawmakers. Your contacts can have an impact on the outcome of certain bills of importance to the medical profession and to you personally. However, these contacts will have much greater impact if personal relationships exist between you and your elected officials.

Most lawmakers want to know as many of their constituents as possible. You should have little or no trouble getting acquainted with them if you take advantage of opportunities to meet them. Both patience and persistence in the development of a working relationship with lawmakers is essential.

Party affiliation should not restrict you. Lawmakers represent their entire constituency - Republicans, Democrats, and independents alike. You need not be a member of your lawmaker's political party nor wait for problems to arise before you approach him or her.

The following information provides guidance on the techniques of communicating with lawmakers.

Getting the Facts

To make your communications effective, some preliminary homework should be done. Find out who your elected officials are and learn all you can about them. Background information on your senators and representatives in both Washington, D.C. and Jefferson City can be provided by MSMA staff. Local libraries and chambers of commerce also are excellent sources of information. Once a lawmaker's background is familiar, it is important to stay abreast of his or her positions on issues. Information gathered through public statements, votes, and demonstrated support will be invaluable in making personal communications.

Meeting Your Lawmaker

Take advantage of every opportunity to meet and become better acquainted with your lawmaker. Opportunities may develop through MSMA, your local medical society, local civic or charitable organizations, or local and state political functions. Relationships initiated through such meetings can evolve quickly into relationships which permit discussion of medical concerns.

Making Personal Contacts

Several types of communications can be effective in building a relationship with your lawmaker. Personal meetings, either to discuss a specific issue or just to introduce yourself as a constituent are obviously the most effective. As a constituent, you can develop and maintain an ongoing, working relationship with the government officials representing your area. These relationships should be developed primarily at a time of no need, i.e. before you have a problem to discuss. In that way, when you do have a problem and need assistance, you can call on them in a personal manner to discuss the problem.

These relationships are best developed by contacts made when the lawmaker is home in his or her district. There are any number of ways to meet these people: over lunch, in civic groups, in their offices or yours, by inviting them to speak to constituent groups, etc.

In these personal contacts, it is most important that you be positive and constructive in your remarks. Prepare well and always be factual. Make officials feel that they are receiving some benefit from the relationship and that they are receiving reliable information on issues.

Given a lawmaker's busy schedule, making personal contacts can be difficult to accomplish, though not necessarily more difficult than any other important contact you normally would make. Unless you already know your lawmaker well, you should write to request an appointment or schedule a meeting.

Keep the following guidelines in mind:

➢ Use your personal stationery or letterhead from your hospital or office.

➢ Address the letter correctly.

➢ State your reason for writing. If extending an invitation or requesting a meeting, suggest a time and date, or several dates, for the visit. Be flexible. Indicate how much time you would like with the lawmaker - typically ten to fifteen minutes if you are alone, more if you're with a group - and state the purpose of your meeting. (You may want to invite a lawmaker to breakfast or lunch. Even a few minutes over a cup of coffee can be very rewarding.)

➢ If the meeting is to discuss a specific issue, it is important to be familiar with all aspects before going into the meeting. When talking to the lawmaker, try to be concise and well organized; demonstrate a regard for his or her schedule. Most of all, state your views firmly but be attentive to the lawmaker's positions as well. The meeting should be an exchange of ideas, not a lecture. You may leave background material if you have it, but keep it brief.

➢ After the meeting, follow up with a letter thanking the lawmaker for taking time to meet with you. Summarize key points which were discussed and answer any questions you couldn't respond to at the meeting. Also, send a note of thanks to those staff people who helped to arrange the visit.

……

Letter Writing Tips

Because much of a lawmaker's time is spent in the Capitol, many of your communications will be written. When writing a lawmaker about a legislative issue it is important to remember the following:

➾ Keep your comments short and to the point. Cover only one issue per letter.

➾ If writing about legislation, identify the subject clearly. Use the House or Senate bill number and title if possible.

➾ State your reason for writing. Explain how the issue would affect you, your family, your practice and your patients.

➾ Be reasonable. Don't ask the impossible. DO NOT USE THREATS. Be courteous and respectful in all communications.

➾ Be constructive. If a bill deals with a problem but seems to represent the wrong solution, propose constructive alternatives.

➾ Take a position. Ask your lawmakers to state their positions on the issues in their replies.

➾ Avoid stereotyped phrases and sentences that give the appearance of form letters. Personal communications are much more effective.

➾ Write when the lawmaker does something that deserves approval. A word of appreciation will create a more favorable light for the next communication.

Contacts by Telephone

On occasion you will want to contact your lawmaker by telephone. Here are some pointers:

✆ Every year, at the start of the legislative session, MSMA publishes the names and telephone numbers of all state senators and representatives in Missouri Medicine. You can also call MSMA for your lawmaker's telephone number. The U.S. Capitol switchboard in Washington, D.C. will give you the number of your Member of Congress. That telephone number is (202) 224-3121.

✆ Keep calm. It is important to sound composed, well-informed, and self-assured.

✆ Be organized. Jot down the ideas you wish to convey to your lawmaker ahead of time.

✆ Be polite but firm. You are a constituent, but DO NOT THREATEN with the power of your vote.

✆ Don't be put off when a secretary asks to take a message. Lawmakers often depend on staff to handle many constituent calls.

✆ Identify yourself, explain why you are calling and why you feel the way you do.

✆ Ask your lawmaker's position on the issue.

✆ If your lawmaker agrees with you, thank him or her for talking with you and encourage his or her continued support. If the lawmaker is undecided or against your position, discuss his or her concerns factually.

✆ Follow a telephone call with a note or letter restating your position and thanking the lawmaker again for his or her time and interest.

Following-Up

Keep in mind that your goal is to develop an ongoing personal relationship with elected representatives in order to facilitate communications on your legislative concerns. Once acquaintances with lawmakers are made, you should:

✉ Keep up with what lawmakers are doing and the votes they cast on issues of concern to you.

✉ Let lawmakers and their staffs know when you are pleased with a vote or position taken. Just like everyone else, they like to feel that their efforts on behalf of their constituents are appreciated. On the other hand, if you disagree with a vote or position taken, don't hesitate to let your lawmaker know.

✉ Invite the lawmaker to dinner parties or social gatherings with other physicians and their spouses, friends and neighbors.

✉ Invite the lawmaker to speak to local medical groups or other groups to which you belong.

✉ Consider getting involved in your lawmaker's campaign for re-election.

Addressing a Public Official

President of the United States
The President
The White House
Washington, D.C. 20500

Dear Mr. President:

State Representative
The Honorable (full name)
House of Representatives
State Capitol Building
Jefferson City, MO 65101

Dear Representative (surname):

U.S. Representative
The Honorable (full name)
United States House of Representatives
Washinton, D.C. 20515

Dear Representative (surname):

U.S. Senator
The Honorable (full name)
United States Senate
Washington, D.C. 20510

Dear Senator (surname):

State Senator
The Honorable (full name)
Missouri State Senate
State Capitol Building
Jefferson City, MO 65101

Dear Senator (surname):

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The Honorable (full name)
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State Capitol Building
Jefferson City, MO 65101

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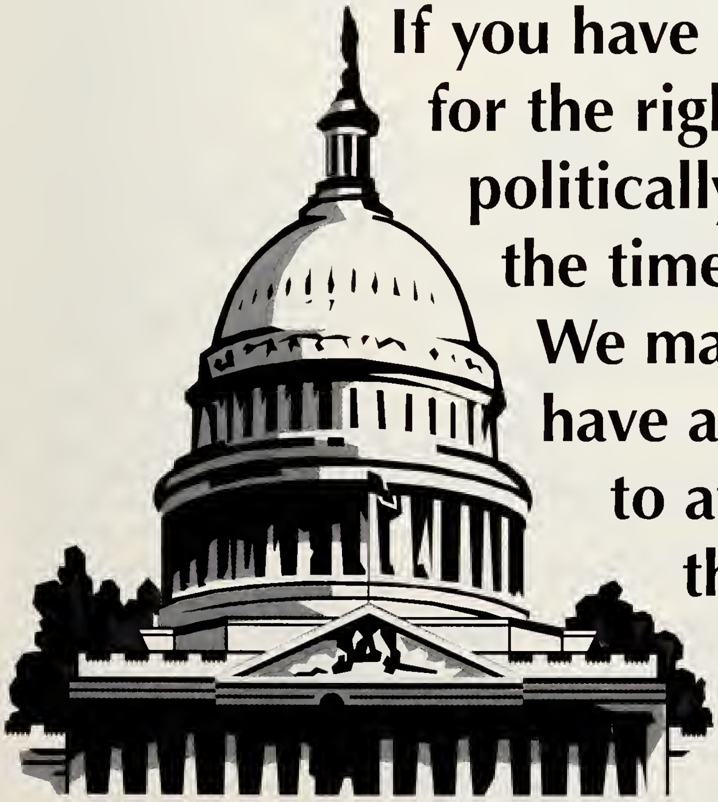

If you have been waiting for the right time to become politically involved, the time is now. We may never again have another opportunity to affect health care the way we can in this Legislative Session. Get Involved!

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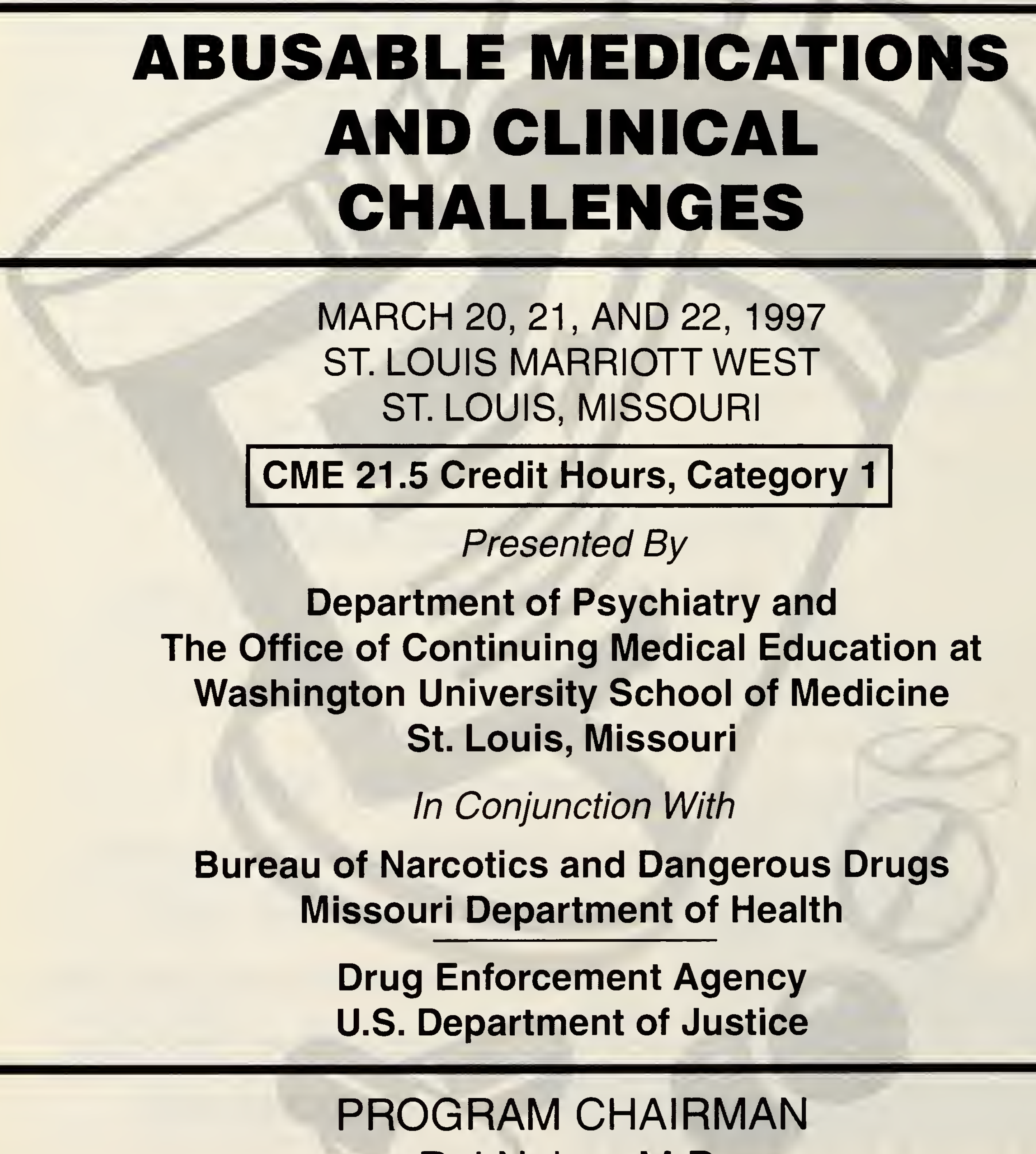

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Missouri Physicians' Health Program

Recognition of Key Supporters

(As of 12/11/96)

The Missouri State Medical Association and the Missouri Physicians Health (MPH) Program would like to thank the following institutions for their generous support to the MPH Program. It is because of these gifts that the MPH Program can continue to assist physicians who are having life problems that prevent them from functioning at their best.

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Western Missouri Medical Center
Medical Staff, Warrensburg

Membership Notes

New Members

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Bridgeton, MO 63044
Johns Hopkins Univ, 1988

Christopher Creighton, MD
P.O. Box 9134
Morgantown, WV 26506
Univ of Chicago, 1987

Malcom Oliver, MD
3323 S. Main
Republic, MO 65738
Indiana Univ, 1989

Mary Rudloff, MD
11133 Dunn Rd. Ste. H1303
St. Louis, MO 63136
Washington Univ, 1979

Archie Sanchez, MD
2900 Baltimore Ste. 650
Kansas City, MO 64108
Univ of New Mexico, 1989

Boone

Matthew Concannon, MD
UMC Div PS One Hos. Dr.
Columbia, MO 65212
Univ of Mo-Columbia, 1987

Michael Cupp, MD
500 Keene
Columbia, MO 65201
Univ of Mo-Columbia, 1990

Dean Hainsworth, MD
One Hospital Drive
Mason Eye Inst.
Columbia MO 65212
Univ of Kentucky, 1990

David Haybron, MD
1701 E. Broadway
Columbia, MO 65201
Ohio State Univ, 1988

Mark Vaporean, MD
1601 E. Broadway
Columbia, MO 65201
Univ of Mo-Columbia, 1986

John Wilkes, MD
115 Business Loop 70 W.
Ellis Fischel Cancer
Columbia, MO 65203
Univ of MO-Kansas City, 1988

Stephanie Womack, MD
1000 W. Nifong #130
Columbia, MO 65203
Univ of Mo-Columbia, 1992

Dudley Zimmerman, DO
117 Broadway
Ashland, MO 65010
Okla St. Univ, 1981

Cape

Saleh Aldasouqi, MD
#55 Doctor's Park
Cape Girardeau, MO 63703
Jordan Univ Amman, 1984

Cole

Randall Mitchem, DO
1603 Independence Dr.
Jefferson City, MO 65109
Univ Health Sciences Ctr, 1987

Chandra Prasad, MD
1505 Southwest Blvd.
Jefferson City, MO 65109
Washington Univ, 1991

Jody Rodgers, MD
1620 Southridge Dr. Ste. B
Jefferson City, MO 65109
Temple Univ, 1989

W. Blake Rodgers, MD
1500 Southwest Blvd.
Jefferson City, MO 65109
Harvard, 1989

Joseph Wang, MD
200 St. Marys Plaza, #302
Jefferson City, MO 65101
Northwestern Univ, 1988

Deborah Weems, MD
1616 Southridge Dr. Ste. 202
Jefferson City, MO 65109
Univ of Mo-Columbia, 1993

Camilla Wheeler, MD
1735 Elm Ct.
Jefferson City, MO 65101
Univ of MO-Kansas City, 1992

Greene

Mark Elder, DO
1443 N. Robberson
Springfield, MO 65802
Univ Health Sciences Ctr, 1993

Steven Otto, MD
1001 E. Primrose
Springfield, MO 65807
Univ of Iowa, 1991

Shari Kelm, MD
4303 N. 16th St.
Ozark, MO 65721
Univ of South Dakota, 1996

Mineral Area

Ajay Upadhyay, MD
605 W. Main
Fredericktown, MO 63645
Maulana Azad-New Delhi, 1980

Northeast

Arnold DeBelen, MD
210 N. 7th St.
Canton, MO 63435
Univ E. Quezon City Philippines, 1988

Perry-St. Genevieve

Briccio Cadiz, MD
930 Park Dr.
Ste. Genevieve, MO 63670
DeLaSalle Univ-Philippines, 1988

South Central

Thomas Reinbold, DO
1337 S Sam Houston Blvd.
Houston, MO65483
Univ Osteo Hlth Sci-Des Moines, 1993

Residents

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Michael Causey, MD
Marcia Chantler, MD
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David George, MD
Barton Giessel, MD
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University of Missouri-KC

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Mary Buss
Afshan Chishti
Jayna Doshi
Meredith Leach
Chad Ruble
Amy Schuepbach
Julie Sturm

Membership Notes

William A. Peck, MD, Executive Vice Chancellor for Medical Affairs and Dean of Washington University School of Medicine in St. Louis, was elected Chair of the Council of Deans for the Association of American Medical Colleges (AAMC). He was elected at the AAMC's annual meeting in San Francisco.

The AAMC is a professional organization comprised of representatives from academic medicine which identifies issues affecting academic medicine and develops strategies to achieve the various missions of medical schools.

Dr. Peck is the first person to serve in the dual position of Dean and Vice Chancellor for Medical Affairs at Washington University. He also is an internist who is internationally recognized for his work on osteoporosis.

Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs.

Robert Bailiff, Springfield
Harry Cohen, Mexico
Walter Dean, Maryville
Jag Devkota, Columbia
James Garner, Kansas City
Larry Halverson, Springfield
Nancy Hayes, Mtn. Grove
Charles Johnson, St. Louis
Edward O'Brien, St. Louis
Larry Stewart, St. Louis
Morris Wise, Kansas City
Leo Wyrsch, Springfield

In Memoriam

Axel Norman Arneson, MD, 91, St. Louis, died November 1, 1996. He graduated from Texas Christian University and earned his medical degree in 1928 from Washington University. After his internship and residency at Barnes Hospital, he spent two years as a fellow at a hospital in New York. He started private practice in St. Louis in 1934. He was a former clinical professor in obstetrics and gynecology and associate professor in radiology at Washington University School of Medicine. He had been on staff at the old St. Louis Maternity Hospital, Barnes and Jewish hospitals, Washington University clinics and St. Luke's Hospital. He retired in 1985.

Barbara Spies, MD, 73, Louisburg, KS, died November 9, 1996. Dr. Spies graduated from the University of Kansas Medical School in 1952, interned at Menorah Hospital, practiced in Kansas. From 1978 until she retired in June of 1987, she practiced in Louisburg.

Oscar A. Carron, MD, 94, Perryville, died November 26, 1996. He graduated from St. Louis University Medical School in 1929. He interned at St. Mary's Group of Hospitals in St. Louis and began practice there until 1932 when he transferred to Perryville. He served as chairman of the Obstetrics Department for the Perryville Hospital for 10 years. He retired in 1976.

Aloysius Gerst, MD, 77, St. Louis, died November 14, 1996. He earned a bachelor's degree from Benedictine College and his medical degree from St. Louis University School of Medicine. Dr. Gerst was head of pediatrics at DePaul Health Center from 1959 until 1972, when he became chief of staff. He was also on the staff at St. Mary's Health Center and Northwest hospitals. He retired in 1985.

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CME Calendar

The continuing medical education accreditation program of the MSMA has full approval by the AMA's Council on Medical Education. The institutions and functions listed here qualify for Category I credit for the AMA Physician's Recognition Award. All accredited institutions in Missouri are invited to send CME information for free listing in *Missouri Medicine*.

JANUARY 1997

8 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.

9 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.

13 - *St. Louis*: Applications of Breast Ultrasound. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

15 & 16 - *Kansas City*: Palliative Care: What are the Choices? 11 credit hours. Speakers: Drs. Alexander Peralta, Jr and Robert Enck. Call Barbara, Truman Medical Center 816-283-4519.

22 - *St. Louis*: The Ninth Annual Joseph E. Flynn Lecture Series. Call 314-569-6290.

27 thru 31 *St. Louis*: Medicolegal Death Investigators. Call 1-800-553-2712.

FEBRUARY

10 - *St. Louis*: New Insights into Costs and Motivations for Self Referral. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

15 - *St. Louis*: Diabetes Update. Call 1-800-553-2712.

21 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.

27 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.

MARCH

6 & 7 - *Kansas City*: Hospice and End-Stage Dementia. 9 credit hours. Speakers: Ladislav Volicer, MD, PhD. Call Barbara, Truman Medical Center 816-283-4519.

8 - *St. Louis*: Hepatobiliary Disease. Call 1-800-553-2712.

10 - *St. Louis*: The Role of Nuclear Medicine in Assessment of Infections. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

12 thru 14 - *St. Louis*: The Tenth National Symposium Noninvasive Diagnosis of Vascular Disease. Call 314-569-6290.

14 - *St. Louis*: Bleeding Disorders. Call 1-800-553-2712.

21 & 22 - *St. Louis*: Integrated Care of the Thoracic Surgery Patient. A Seminar for Allied Health Professionals. Call Washington University School of Medicine 314-362-6891.

APRIL

11 - *St. Louis*: Allergy for the Clinician. Call 1-800-553-2712.

14 - *St. Louis*: Leroy Sante Lecture. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

18 - *Lake Ozark*: Mental Health and Aging. Call 1-800-553-2712.

21 thru 25 - *St. Louis*: Medicolegal Death Investigators. Call 1-800-553-2712.

25 - *Branson*: Update: Primary Care. Call 1-800-553-2712.

MAY

12 - *St. Louis*: Radiologic/Pathologic Correlates in Bronchogenic Carcinoma. Call R. Gilbert Jost, MD, Malinckrodt Institute of Radiology at 314-362-7130.

JUNE

9 thru 11 - *St. Louis*: Strengthening Instructional Skills. Call 1-800-553-2712.

21 - *St. Louis*: Summer Geriatrics Inst. Call 1-800-553-2712.

JULY

28 thru 31 - *St. Louis*: Masters Course: Death Investigators. Call 1-800-553-2712.

Classified Advertising

Position Wanted: Board Certified Internist with 14 years of practice experience, currently enrolled in a fellowship at a university learning procedural skills in cardiology, gastroenterology, and pulmonary medicine. Desires to relocate at the completion of training in the summer of 1997. Please address enquiries to C/O Position Wanted, Missouri Medicine, P.O. Box 1028, Jefferson City, MO 65102.

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Board Review-IM: Start early register for the Course, June 20-25, 1997, Columbus, Ohio, or Home study with text or video. Voice mail at 614-631-2756.

YPMA sought for Sarah Bush Lincoln Health System. Innovative restructuring has identified the need for a full-time dedicated physician leader. Skills in consensus building, program development, and Quality Assurance/Utilization Management with relevance are essential. Additionally, an awareness and enthusiasm for the business aspects of health care and how to prosper, not just survive, under managed care is required. For additional information, please contact Christine Mackey-Ross, RN, at 314-862-1370, or by mail at Witt/Kieffer, Ford, Hadelman & Lloyd at 8000 Maryland Ave., Ste. 1080, St. Louis, MO 63105, or by fax with cover at 314-727-5662.

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Missouri Medicine

Journal of the Missouri State Medical Association February 1997

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"Sobering Facts"

J. Regan Thomas, MD, Editor

A recent report issued by the Department of Health and Human Services contained unfortunate news for the nation's teenagers. The report was based on interviews of 50,000 students representing more than 400 schools, both public and private.

One of the findings showed that there was a 10 percent increase in smoking among eighth graders over the past year. Additionally, smoking has increased 50 percent for this group since 1991. Now, 20 percent of eighth graders are smokers.

We need new and innovative ideas to present teens with convincing, honest and factual information that will discourage them from abusing drugs, alcohol, or tobacco.

Alcohol use did not significantly increase, but it was already quite high. The study noted that 10 percent of eighth graders admitted to being drunk in the past month.

The most dramatic increase was in marijuana use. There was a 250 percent increase among eighth graders (150 percent increase for tenth graders). One in five tenth graders report using marijuana in the past 30 days.

Obviously, something is very wrong with how we are dealing with the problem. Many kids seem to be saying "no" to our efforts to educate them on the dangers of drug and alcohol use as well as smoking.

Millions of dollars have been invested to discourage kids' smoking and substance abuse. One of the best known is the DARE program (Drug Abuse Resistance Education). This is a school-based program that incorporates police officer presentations with the strong message to avoid drug use. Now, a number of school systems have canceled the program due to poor results. Fayetteville, North Carolina; Oakland, California; Seattle, Washington and Spokane, Washington have all dropped DARE after inability to document any justifiable level of success.

So what is happening? Why have these obviously well-intentioned efforts gone unrewarded? A recent public radio interview with teens who were former drug users and reportedly now drug-free mentioned two problem areas. First, they felt the message comes too late. They felt that efforts should begin at early elementary school age. Secondly, they suggested that the message was too propaganda-like, unrealistic, and no

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match for peer pressure.

Other critics suggest that some of the claims aimed at discouraging marijuana use simply do not seem credible to teens.

> **Today's children and teenagers are more sophisticated about picking up on messages which are misleading or half-truths.**

For example, the implication that "pot smoking" will lead to hard drug use. Kids likely know a number of grown-ups who smoked marijuana or drank as teenagers and are now respectable adults who did not become hard drug abusers. Donna Shalala, Secretary of Health and Human Services, agrees that the problem is fueled by teens who believe marijuana is not harmful. She also notes the problem of parents who used drugs during their own youth and are now reluctant to discuss the dangers with their own children.

A December 26th editorial in the St. Louis Post-Dispatch on this topic also suggests the peer pressure message carries more weight than the official line. They noted a common scenario where a teen who has experimented with marijuana tells his friends that "...the consequences aren't nearly as terrible as they have been led to believe." The antidrug message surely begins to unravel in this situation.

There is consensus that present programs are not satisfactory. Today's children and teenagers are more sophisticated about picking up on messages which are in part misleading or half-truths. But it is not enough simply to scrap the present programs. We need new and innovative ideas to present teens with convincing, honest and factual information that will discourage them from abusing drugs, alcohol, or tobacco. Step one is recognizing that the status quo is not acceptable. The next steps may be more difficult but must be pursued. It must be a multifaceted approach. Parents must, of course, take an active role and talk specifically about drug and alcohol use and its dangers. They must be willing to set rules and consequences.

Schools must be allowed to be part of the answer, but must be realistic, logical, and deal with the issue in a fashion that is meaningful to the kids. Society at large, including the entertainment industry, must be responsible and avoid glamorizing or promoting drug use. The medical community must also take the time and energy to reinforce this important concern in our contact with these young people. **MoMed**

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"Physician-Assisted Suicide: Primum Non Nocere"

Daniel O'Sullivan, MD, MSMA President

At the 1996 American Medical Association Interim Meeting in December, held in Atlanta, Georgia, a number of radio interviews were arranged for your President to report back to the citizens of Missouri exactly what issues were being debated in that forum. Other Missouri Delegates conducted similar conversations with the media in their home communities. The opening question in nearly every case involved the controversy over physician-assisted suicide. Among the leaders of American medicine, this is a non-issue. The overwhelming testimony in Reference Committees and in the House of Delegates was against this practice. Only a handful of speakers were in favor.

A single doctor in Michigan has publicly assumed the mantle of moralist for us all, and the legality of his decisions was recently debated in the Supreme Court of the United States. Confusion exists in regard to definition. Physician-assisted suicide is the practice of supplying the means and/or providing the circumstances for another person (presumably a patient) to end his or her life. According to publicity, the patient must harbor a terminal condition from which escape constitutes ethereal release. Technically, the physician acts as an assistant who aids and abets, but does not directly deliver the death blow. Let's dissect this scenario.

The means which the terminator provides has varied in many of the reported cases. Should he or she bring a loaded pistol? A common means is a device for delivering carbon monoxide. Perhaps an intravenous administration of pentothal or potassium chloride or some other cardioplegic drug might be appropriate. Who starts the IV? Who ties the plastic bag around the neck or turns on the machine? Even worse, who holds the barrel of the gun to the temple? As is true of many surgical procedures, the record does not always reflect who was the operator and who the assistant.

The second problem involves the patient. What criteria make an individual a candidate, and who is the judge of those qualifications? We have all agonized over the pain and suffering of patients or loved ones with hopeless conditions which will certainly end in death. Is malignancy an indication for physician-assisted suicide, or are other means available to provide relief from suffering? Some neurological conditions with known courses, such as amyotrophic lateral sclerosis have been suggested. What about migraine headaches, schizophrenia, and Alzheimer's Disease, and who, please advise, will make those judgements?

Since the beginnings of treatment of illness and disease, the individual delivering care has been motivated by the urge to make the one afflicted better. Hippocrates was clear on our primary purpose: "First of all, do no harm." Since the time a wide-eyed boy or girl first proclaims, "I want to be a doctor," until that day when a sheepskin is awarded, the driving force that makes one persist in the turbulent journey of medical education is the prospect that a life could be saved or a sick person healed by his or her efforts. It escapes my imagination how teeing someone up to "escape this mortal coil" constitutes medical care. How do you code that procedure?

Jo-Ellyn Ryall, MD, Delegate to the AMA from Missouri and a practicing psychiatrist in St. Louis, pointed out the real issue to the House of Delegates. When an individual asks to die, particularly because of pain, that person is quite likely crying out for help because of depression, frustration, or inadequate pain control. The request to die might reflect our failure as physicians to offer all the options available. Hospices, pain clinics, and counselling are all available in most communities.

A hair-thin line divides physician-assisted suicide from euthanasia and murder. An act which results directly in death is significantly different from the decision to withhold or withdraw life support or other extraordinary means of prolonging life. Many patients opt against chemotherapy or irradiation, and this is often a reasonable choice.

On a personal note, I find myself sitting down with the nurse saying, "If he hurts, treat his pain. If he wants to sleep, give him a sedative. Most of all, make him comfortable."

We need to remember, "Primum non nocere." MoMed

Missouri State Medical Association's 1997 Annual Convention will be held April 10-13, 1997 at the Westin Crown Center, Kansas City.

This Annual Convention will feature numerous activities and scientific programs in addition to the MSMA Alliance events. This is an excellent opportunity for you to receive Continuing Medical Education.

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1997 Convention Deadlines

- **Citizenship and Community Service Awards** Nominations should be submitted in writing to the MSMA office or through a local component medical society. **January 22, 1997.**

- **Resolutions for Delegate's Handbook:** Resolutions may be submitted by individuals, component medical societies or groups of physicians. **February 24, 1997.**

If you have meeting information to include in the Official Program of the Missouri State Medical Association's 1997 Annual Convention, please call Mr. Ron Ellison 573-636-5151.

Preregister NOW!

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MSMA General Session Speakers

Mr. Steve Wetzell
Bloomington, MN

MSMA General Session

April 11, 9:00-10:30 a.m.

Mr. Steve Wetzell is the executive director of the Buyers Health Care Action Group (BHCAG), a coalition of 24 Twin City-based employers providing health care for 400,000 employees, retirees, and dependents throughout Minnesota, western Wisconsin and eastern North and South Dakota.

MSMA General Session

April 11, 2:30-4:00 p.m.

Mr. Edward Hirshfeld is Vice President and Associate General Counsel for Health Law of the American Medical Association (AMA). He directs the Health Law Division of the AMA, which is responsible for medicolegal policy initiatives and for counseling the Association about health law issues. The Health Law Division is responsible for coordinating the AMA's initiatives in the managed care area.

Edward Hirshfeld, JD
Chicago, IL

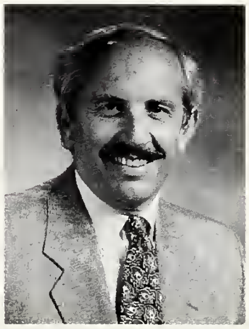
Mr. Robert F. Leibenluft is Assistant Director for Health Care of the Federal Trade Commission's Bureau of Competition. Mr. Leibenluft writes and lectures extensively on health law topics. His articles on health care have appeared in The New England Journal of Medicine, Vanderbilt Law Review, The American Journal of Psychiatry, Business and Health, Pharmaceutical Executive, Medical Devise & Diagnostic Industry, The BBI Newsletter, and other books and journals.

Robert F. Leibenluft
Washington, D.C.

Organized Medical Staff Section General Session

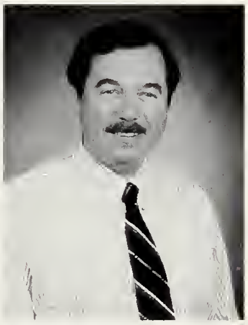
April 12, 10:00 a.m. - 12:00 noon

Joseph Green, PhD, has served as Director of Continuing Medical Education and Vice President of Medical Education for Sharp HealthCare, an integrated health care system in San Diego, Ca., since 1989. He is also president of Professional Resource Network, Inc., a consulting firm which has provided assistance to several national specialty societies, medical schools, voluntary associations, and hospitals.



Joseph Green, PhD
San Diego, CA

Robert Pyatt, MD, is serving as the acting Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians. He has been serving for the past four years as an ACCME national surveyor. Dr. Pyatt has been selected to serve on the Board of Examiners with the 1996 Malcolm Baldridge National Quality Award; only a few physicians in the United States are selected for this honor, and he is the first member of the CME community who has achieved this status.



Robert Pyatt, Jr., MD
Chambersburg, PA

Health Care Change: How Clear is the Crystal Ball?

Timothy McIntire, MD, MBA

Value, a word with many connotations.

We all try to bring "value" to our medical practice every day. When will our "value" be appreciated? When will the HMOs appreciate our "value," not just the amount of discount we give them on our fee schedule? When buyers of health care stop assuming quality and value, and they begin comparing physicians on quality and value, how will we react? How will we compare? How do we compare among ourselves now? Do any of our practices track quality, cost and value indicators? Who will judge the value of our decisions and treatments?

Just as we have limited clout in the price employers demand from health insurers, and health insurers demand from us, just as we have almost no clout in the price Medicare gives us for our services, we will have equally small influence as employers, insurance companies and the government decide to define and judge value. In Steven Shortell's book Remaking Health Care in America, value is defined as a combination of price and quality attributes as judged by the purchaser or consumer. Currently, we as physicians do not define the rules of the game. However, as consumers get more sophisticated, as medical data management is shared and studied in large business purchasing cooperatives, and as price competition gets squeezed out of the market, quality and value will emerge as the market differentiates among health care providers. Just what we as physicians have been waiting for ! ?

Do you belong to an organization that can afford a major information system? Does it also have the personnel and financial resources to effectively collect, collate, and manage the data into information other physicians can use as they take care of their patients? If not, how will you be able to compete on anything but price? Data is the "jet fuel" that powers the information systems which are rapidly developing in medicine. If you are on vacation one thousand miles from home and can access cash from your checking account, after hours, by an ATM, then how long will it be before consumers can access electronic data on health systems and physician profiles, services and locations?

Medicine is rapidly changing, and physicians who hope to practice in the next century are trying to identify these changes and find opportunities to effectively deliver health care to their patients.

Consolidation

Information and the market changes in the health care delivery system are forcing consolidation of providers, insurers and buyers. Physicians will not be able to compete on a solo basis much longer, if at all. Value is to be defined as "the continuum of care" and how price and quality relate to that continuum.

1990s Integration

Integration is a buzz word all physicians have been hearing for two decades. Integration, as previously defined by hospital systems and health insurers, meant mergers and acquisitions. This related strictly to a business

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and financial exercise attempting to achieve a critical economy of scale to better compete on price, thus gaining the beloved market share needed to fuel their cost machines. However, the core concept of integration is slowly changing. Integration of the late 1990s will evolve along three dimensions: clinical integration, physician - system integration, and functional integration (financial, human resources, information systems, total quality management, etc.). The opportunity for physicians to recapture a driving influence in the large scale delivery of health care will come from the development, implementation, and management of the following:

** Standardized information systems to promote physician and clinical integration (the data/ information feedback loop to efficiently deliver care),

** Total quality management to promote physician and clinical integration (decrease duplication of services and allow more efficient delivery of services along the continuum from physician offices to outpatient ancillary testing, to inpatient episodes of care, to post acute care, and back to the physician's office),

** Physician-system integration promoting clinical integration (developing " best practice" guidelines for inpatient care, chronic disease case management networks in physician clinics, and monitoring the health status while coordinating preventive care in the community),

** Systems with more physicians practicing in groups, experiencing greater net cash flow (if we are to drive this new system, we must be financially sound to support the changes and keep secure our patient base).

Manage the change,
be flexible in your practice,
grow your patient base,
and affect the lives and health
of not only the patients you touch,
but the community we all live in.

All of a sudden, integration can have a different connotation if physicians, as patient advocates, can organize and make sense of the chaos known as the consolidation of health care delivery.

21st Century Integration

Physicians are realizing health delivery is a long distance race, not a sprint. Once consolidated, physician organizations (groups, POs, IPAs, etc.) must have a clearly articulated vision, and they must focus on limited strategic priorities. Physicians must develop group cultures that both embrace and manage change. They must use the patient care information they possess to make and implement decisions more quickly.

Physicians must be aggressive in the marketplace and continually focus on patient care, governance and the management issues which confront them. Whether physicians are employed by insurers, hospital systems or medical groups, they must prioritize information systems as a core competency in patient care. Academic research centers have often given community physicians information on new technologies, new pharmaceuticals, and new procedures. Community physicians must now begin to generate their own information to affect the long term value received by their patients.

Defining Culture

Physician organizations with strong total quality management, information management, and physician leadership are more likely to add value when they take comprehensive responsibility for delivering the continuum of care. We cannot demonstrate value unless we can define it, understand the underlying processes for its creation, measure it, and reward it. Large physician-led organizations will be able to overcome the barriers to sophisticated information systems. Governance issues which hold physician groups together and financing vehicles which will allow our organized systems to demonstrate value, will be able to measure quality, emphasize patient satisfaction and outcomes, and not be a slave to "just price."

Best Practices

Inpatient clinical pathways,

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which organize acute care delivery into protocols, deliver good care in less time and at lower costs. As physicians, we understand that many of these best inpatient practices are an efficient mechanism to solve a failure of outpatient therapy. For example, chronic diseases such as asthma, COPD, diabetes and drug interaction complications are managed on an ongoing outpatient basis. It is only the acute exacerbation of these chronic diseases, often the result of patient noncompliance or poor patient support systems and education, that allows us the opportunity to use these efficient inpatient protocols. If we can develop a chronic care, multidisciplinary approach to these diseases, we may be able to truly affect health status and costs. These types of teams often require more resources than a small clinic can afford. However, as physicians consolidate resources into larger patient care projects, chronic care outpatient disease management systems will develop on a greater scale. An example of a disease management outpatient project, a Coumadin Clinic, is explored in a sister article in this issue. Outpatient chronic disease programs such as Coumadin Clinics, asthma clinics, COPD clinics, and diabetes clinics offer an efficient multidisciplinary approach to the case management of these costly and progressive diseases. Physician-directed disease management programs will allow the delivery of quality, low cost, efficient care, while offering better long-term patient outcomes than the current episodic care delivered in the inpatient setting.

It is a fact that medicine is getting larger and larger. The practice of efficient medicine in the future will be cemented in a foundation of wellness, preventive care, and chronic disease outpatient care (disease management). These efforts will be driven by physicians, but not without significant help from many varieties of allied health providers. The buyers of health care will hold us to the high quality we currently deliver, continue to measure that quality, and demand that it is delivered at a lower cost. A lower cost means both lower cost per episode of critical care and a lower total patient disease cost over time. By decreasing outpatient complications such as noncompliance and poor patient education of their disease states, we can achieve those cost targets.

Results

Is your crystal ball clear or cloudy? Can we, as physicians, take control of the health care delivery system, regardless of how the integration of health plans and hospital systems occur? Are we really the resource everyone is hoping to control to deliver better health care to our patients? Can we organize into critical masses at a local level, then network on a regional level to provide better health care than non-physicians? Can we organize among ourselves, then ally with other hospitals or health insurer systems to reach the momentum needed to deliver Twenty-first Century community care? Will physicians be able to lead this venture? The answer will be "no" if we hide from the changes of consolidation and do not organize and govern ourselves as a big business. Is the answer "yes" if we are proactive and consolidate parallel to our changing industry? This is our only hope. Chronic disease clinics, such as the Coumadin Clinic article in this issue, are examples of physicians giving up some control in direct patient management to more effectively and efficiently affect the health care status of their patients and their community. This should be a good trade. Manage the change, be flexible in your practice, grow your patient base, and affect the lives and health of not only the patients you touch, but the community we all live in. MoMed

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Coumadin Clinic: A Disease Management Enterprise

Timothy McIntire, MD, MBA

Disease management is a "managed care" term relating to the coordination of both outpatient and inpatient care as it relates to chronic disease states. Programs typically focus their efforts upon diseases or conditions that are chronic and costly, yet controllable. The goal is to identify complicated or noncompliant patients, either in the outpatient setting or upon discharge from an acute admission. Once these patients are identified, patient education, the social aspects of care, medication compliance monitoring, and the prevention of complications are targeted.

Disease management programs are best suited for diseases which are chronic or recurring in nature, conspicuously expensive, have controllable results, have frequent but avoidable acute episodes of care, occur in a large patient population, and have the opportunity to control costs, patient compliance, and outcomes. There are many illnesses which lend themselves to disease management protocols, including: asthma, diabetes, cardiovascular disease, cancer, epilepsy mental illness, COPD, AIDS, etc. These chronic conditions account for 70% of all health care expenditures, including 80% of hospital admissions, 90% of inpatient days, 75% of total prescription drug charges, and 70% of laboratory and x-ray charges.

Physicians have long understood that an acute admission for these certain diseases is often simply a failure of outpatient care. These failures may be due to a lack of access, noncompliance, or nontherapeutic medication levels. As physicians search for better quality and cost effective overall care, disease management systems will become more important.

The following Coumadin Clinic is an example of the characteristics needed to assess and implement one portion of a disease management system. This template was used in a Southern California Integrated Health System with success. Consideration of such programs in our communities should follow.

A Coumadin Clinic's primary function is to monitor patients on Coumadin therapy maintaining and assuring proper anticoagulation, while preventing or minimizing any adverse effects. A clinical pharmacist or physician champion accomplishes this by focusing on patient education, frequent monitoring, regular communication with the patient, and consultation with the patient's physician. By providing a standardized medical protocol, intensive patient education, and regular follow-up, the patients receive consistent long-term outpatient care. The cost effectiveness of the care this clinic delivers will be proven over time as the complications non-therapeutic levels are decreased.

Patients with chronic disease often receive care from multiple physicians they have encountered over the course of their disease. Patients are easily confused when multiple physicians and therapies are encountered. These problems are compounded with an elderly population in open access or non-gatekeeper insurance models.

The disease management goals of a Coumadin Clinic should address the needs of maintaining appropriate anticoagulation, patient education and awareness, minimizing adverse effects, standardizing therapy, continuity of care, and cost effectiveness.

Once the need for the clinic is established, several operational aspects and resources should be addressed including the financial, personnel, and space resources needed, the number of patients to be served, the information systems required, identifying interested and integrated physicians, and the development of appropriate protocols and forms. Logistical considerations for the clinic include the location, the accessibility, and the ability to transmit information. Disease management programs rely on information systems to converge data from a variety of sources into guidelines,

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protocols and algorithms for the treatment of certain diseases and conditions. Claims data, computerized patient charts, expert opinions, outcomes data and pharmacy benefit management files are integral tools for the effective development of disease management programs.

Patient enrollment occurs from several avenues, some of which include, discharge from the hospital by the discharging physician, referral by physicians within the network, referral by clinical nurse specialists (rural networks), and referral by attending physicians or medical directors of participating skilled nursing or long-term nursing care facilities.

Patients are seen at the clinic initially for consultation and are educated about their therapy during their first appointment. They are then assigned a treatment goal based upon their diagnosis if no goal was indicated by the referring physician. Patients then have their Coumadin dosage and prothrombin times (INRs) managed by a clinical pharmacist or physician champion.

Those who are therapeutic on their dosage regimen will have their prothrombin time retested every four-five weeks. Those who are not stable will have their prothrombin times tested at the discretion of the clinical pharmacist or physician champion, usually within one-two weeks.

Patients are phoned with their prothrombin time results and are informed if there are any necessary changes in their Coumadin dose. Repeat prothrombin time tests are also scheduled at this time. Progress notes are generated with information relating to subjective complaints, objective data (PT, INR, goal, Coumadin dosage), assessment, and plan of action. A copy of this progress note is forwarded to the patient's outpatient medical record. Attending physicians are consulted regarding any peculiar laboratory results, complications of Coumadin therapy or other medical needs. The quality improvement programs of the Coumadin Clinic focus on and assess the effectiveness of the services provided by the clinic.

In an effort to monitor the appropriate levels of therapy, a continuous measurement of the percent of patients that are within the desired therapeutic goals is undertaken. An evaluation and feedback mechanism for panic results is established. Monitoring the number of hospitalizations due to bleeding complications and subtherapeutic anticoagulation is followed. Identification of drugs/drug interactions that may potentially cause adverse effects is also tracked.

A financial model can be developed to track the costs of the clinic as compared to the costs and frequency of hospitalizations and complications, both at the onset of the clinic and over time.

Patient education is the foundation of any disease management model. Developing and monitoring the patient's progress is measured by the establishment of goals to increase the understanding of Coumadin therapy by the patient and their family, to increase and measure the drug compliance, and to increase the patient awareness of adverse effects thus allowing early detection and treatment.

Patient education must lead to patient compliance to effectively treat and monitor chronic disease patients. A few areas notorious for difficulty in patient satisfaction include: addressing specific patient needs by the clinical pharmacist or physician champion, reporting laboratory results in a timely manner, and the accessibility of the Coumadin Clinic and the clinical pharmacist or physician champion.

In settings where Chronic Disease Clinics such as this Coumadin Clinic have been implemented, excellent results have been encountered. Coumadin Clinics often have high patient satisfaction in the education, access and compliance areas. Areas which usually need continuing improvement include the ease of accessibility to the clinical pharmacist or physician champion, and specific patient education as it relates to the effects of vitamin K containing foods and alcohol consumption while patients are on Coumadin therapy.

Disease management programs maintain the potential to create a new level of cooperation among physicians, HMOs, pharmaceutical companies, and pharmacy benefit managers. We are still in the developmental stages of this new wave of care, and we should not be discouraged by the tools for management we currently have. In time we will develop the systems needed to bring the chronic care our patients require to a higher, more efficient level. MoMed

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Physician Organizations: Historical Fact vs. Current Reality

W.L. Douglas Townsend, Jr.

The author will present his views on physician organizations on Saturday, April 12, during the 1997 MSMA Annual Convention at the Westin Crown Center in Kansas City.

Introduction

In its most basic form, the health care landscape is comprised of three major constituencies:

1) **Buyers** of health care insurance and services (i.e. employers, government)

2) **Insurers** of health care services (i.e. HMOs and indemnity plans)

3) **Providers** of health care services (i.e. physicians, hospitals, pharmaceutical)

As annual health care expenditures in the "unchecked" environment of fee-for-service escalated to levels approaching 14% of gross national domestic product, buyers of such services finally flashed the red stop light and began calling for cost controls. Politicians, sensing opportunity over the alarming trends in health care which included the politically sensitive issue of increasing numbers of under- and uninsured, got into the act culminating with the election of Bill Clinton in 1992 who made health care reform one of the central themes of his campaign platform.

While the Clintons' (Bill's and Hillary's) attempts to overtly reform the U.S. health care system failed, their efforts were largely successful from the standpoint that the simple threat of government intervention lead to a reawakening of the entrepreneurial health care spirit. Almost overnight, a renaissance occurred, causing an industry, in the desire for continued free enterprise, to rebuild itself.

As one would imagine, the reconstruction of health care has brought the greatest burden for reform to the insurers and providers. And, within this segment, many argue the greatest burden for change is incumbent upon physicians. Distilled to its lowest common denominator, what historically held true in health care may be a far cry from the current realities of today's market. Written with the physician's viewpoint in mind, what follows is a series of seven historical health care facts and how they relate to today's volatile environmental realities.

Historical Fact #1: *The income I personally generate from my practice affords me the opportunity to create long-term personal wealth.*

Current Reality #1: *Long term wealth is still possible, but will come through the value of physician stock ownership in the clinic organization.*

Physicians have historically provided services to the health care market as a group of small and fragmented proprietors. As of 1995, 65% of all non-federal physicians were in groups of less than three individuals. The typical practice was structured as a Sub Chapter "S" organization where all income, after direct overhead, was distributed to the physician(s) under the notion of "don't keep capital in the business because you have to pay taxes on it." This capital was inevitably redeployed to the physician's personal use and essentially lost forever as an asset to the clinic organization. Many physicians have created considerable personal wealth under this model.

The playing field today is different. Capital, historically distributed from the clinic, will now have to be retained and this means declining current incomes to the physician. And yes, like any U.S. business, physicians will have to pay taxes on capital retained in the clinic. The ultimate payback, however, comes from the value that can be created in the equity ownership of a going concern business enterprise. Today, the best investment physicians could make (even with the Wall Street "Bull" market) is to reinvest in their own clinics to insure they can remain viable entities in a reforming landscape. The future value of equity ownership in a physician organization with a

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dominant position in its local market place can be unlimited. Look at any of the major creations of wealth by individuals going back to the Rockefellers, Morgans and Vanderbilts, and one will generally observe that such wealth was created through equity ownership, not current income.

Historical Fact #2: *I like to practice medicine and not be worried with the business aspects of my clinic.*
Current Reality #2: *You can still practice medicine. You can ignore the business aspects of your clinic. You will earn less and less each year.*

Reimbursement to the physician is becoming more and more complex. With the advent of managed care, the first challenge was performing identical volumes of procedures for less (discounted fee-for-service). Increasing focus on utilization next led to performing less procedures for less reimbursement. And as the downward pressure on per member-per month premiums continues to challenge payor groups, the desire to cede risk in the form of capitated reimbursement becomes more acute. And rest assured, "just getting more contracts" at any price is not the recommended approach.

Failure on the part of physicians to take the necessary steps to more properly analyze and address the business impact of these changing reimbursement patterns could result in incomes declining annually for the foreseeable future.

Historical Fact #3: *Business people do business plans. Doctors practice medicine.*
Current Reality #3: *Business and medicine are merging.*

While it may be possible for physicians to hang on as fragmented providers in discounted fee-for-service markets, in regions where capitated reimbursement becomes the prevailing form of payment, the introduction of time-tested business concepts to the physician's practice will become a necessary prescription for survival. The first time-tested concept is capital retention. Businesses retain capital as a means of cushioning against periods where outflows of cash exceed inflows and also as a means of providing ongoing capital to invest in new products and services to grow the business and thus the value of the underlying equity. Reliable personnel and financial systems are required to adequately measure the inflows and outflows of cash to send up red flags when the outflows consistently exceed the inflows. Capital must be invested in additional physician and employee resources to market the practice to payors, broaden physician market coverage, improve service levels, and design new approaches that offer better service even at lower cost.

Physicians cannot do this in their spare time.

Historical Fact #4: *Patients are profit centers.*
Current Reality #4: *Patients are cost centers.*

Capitation. It is a sophisticated word that veils the true reality. "Insurance underwriting or risk-taking" is certainly more descriptive of what happens when a physician takes capitated reimbursement. This insurance risk can become a particularly acute problem when physicians begin accepting capitation for covered services which they have to purchase outside their clinic (i.e. total professional services capitation or capitation that includes delivery of ancillary services such as x-ray or imaging). Even for physicians that take capitation only for those services they can directly provide, the financial risk is prevalent. Take the time to calculate a simple, but rough monthly ratio which examines the quotient derived from total capitated payments received for an enrollment pool, divided by the number of times such enrollees visited your clinic. Expect that quotient to bounce around from month to month, but one should be able to regress a line that shows a consistent average. If that average quotient continues to trend downward, the physician is obviously making less and less on a per unit basis than he/she did in previous months.

The solution to the "simple, but rough" calculation above is that the clinic ultimately needs to be capable of calculating its cost down the penny for every CPT code for which it bills. Said another way in conventional business terms, it is "cost accounting." Ask any insurance executive what the key to profitably managing insurance risk (ignoring the ability to maximize returns on premium float) and they will tell you it is two things:

Create critical mass. This means the bigger the denominator pool of an insured population is, the more immaterial the adverse development risk of one case becomes.

Information to quantify risks. Insurance companies hire armies of actuaries to quantify probabilities of certain events occurring coupled with the likely costs associated with satisfying insurance claims likely to arise from such events. Such data is the cost information insurance companies use (ignoring impacts of premium investment income) to price the premium they will charge to underwrite a given risk.

So, for those physicians interested in their annual income, a patient today represents a very different financial opportunity than did the old non-managed, fee-

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for-service patient of yesteryear. Usually, change represents opportunity. And, that is the case with physicians and capitation as you will read in the next fact and reality. But for capitation to be an "opportunity," there has to be a reckoning on the part of the physician that the "business" of his/her practice is as fundamental to success as is the provision of quality medicine.

Historical Fact #5: *Managed care has managed costs.*
Current Reality #5: *Managed care needs to manage health. Only doctors can manage health.*

Let's think theoretically and close to home for a moment. Imagine the malpractice insurance carrier that comes up with a novel (and patented) risk management program for its insureds that enables it to lower by half the incidence of malpractice claims per 10,000 visits. While it may choose different marketing strategies to take advantage of this competitive edge, the insurance company could elect to continue to charge premiums at market rates with the rest of its competitors. But when you examined the profitability of the different insurance companies, you would see our theoretical firm would be much more profitable than its competitors, at identical premium levels.

Physicians' ability to manage the **health** of a population is, likewise, a competitive advantage. This is especially true as the battle over ownership of declining health care premiums between payors and providers becomes more acute. Payor organizations have been very successful in managing and reducing the costs of health care delivery. But such cost management will ultimately reach a point of equilibrium (stabilizing premiums) and the future focus will necessarily move to mitigating the acuity of sickness through the proactive management of health. That value is best created and delivered by organized and informed physicians. As the market shifts to managing health, **organized** physicians will be perfectly positioned to capture larger percentages of the premium dollar because they deliver the "value." But as you will see, this capturing of the value will only be an opportunity for those physician practices that take the necessary steps to organize.

Historical Fact #6: *Poorly organized physicians could control their destiny.*
Current Reality #6: *Poorly organized physicians cannot control their destiny. Organized physicians providing quality medicine with proper business controls can control their destiny.*

GOAL:

Create a physician organization for a given market that invests in the requisite infrastructure to enable it to profitably operate under a globally capitated reimbursement setting.

STRATEGY:

1) Broaden physician networks with an objective of a minimum 50% mix of primary care physicians and with the proper number of physicians that can adequately service the defined market segment.

2) Create infrastructure especially in the area of information systems (both financial and managed care) that helps the clinic to assume risk contracts safely and,

3) Continue to invest in management resources that allow the clinic to compete as a business.

Remember, buyers of health care services (exemption for the government here!), insurers of health care services and most non-physician providers of health care services are all run as businesses. Failure of physicians to become organized will forever put them at a relative disadvantage in the battle for ownership of the health care premium -- even though the "relative value" for their services will increase in importance as our system matures.

Historical Fact #7: *Patients need their physicians.*
Current Reality #7: *Patients need their physicians.*

All quality health care delivery systems have physicians as the centerpiece. That's the good news.

The potential bad news is, failure on the part of physicians to address the business issues that are here (and not going away), will leave them as continued centerpieces of the delivery system, but with financial remuneration that reflects very poorly on the relative value contributed. MoMed

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Cash is King

(Part II)

Gary White, CPA, MBA

An article that I wrote which was published in the October 1996 issue of ***Missouri Medicine*** presented ideas on increasing cash flow to your practice from the patient registration, billing, and collection areas. In this article, I will share ways to increase your cash and profits, by analyzing and reducing your practice overhead expenses.

The November 25, 1996 issue of ***Medical Economics*** cover story is "Practice Expenses Creep Back Up." With the continuous reduction in third party payments for your services, control, and reduction of your practice overhead costs is essential to the profitability of your practice. Especially important is the fact that for every dollar saved in overhead is a dollar added to your practice profits!

A first step in analyzing your practice overhead is to try and obtain industry ranges by expense category for your particular specialty. Sources include your outside accountant, MGMA Annual Cost Survey reports, Society of Medical/Dental Consultants, and others. As the low to high ranges by category vary by specialty, I have included Schedule A (see page 71) as an illustration only of the type of review you would like to perform.

Based upon this type of analysis, you would then review more specifically each category of overhead expense, starting with those expenses which appear to be in the "high" range. Examples of the types of questions you should ask are as follows:

Salaries

Salaries and benefits are generally the largest individual expense category in your practice. Factors to consider include:

1. **Wage rates.** Perform comparative reviews of rates and ranges in your community.
2. **Skill mix.** Look at the tasks each individual performs. Do they require training, skills and compensation of the person? By reallocating tasks, you may be able to provide services with a less costly skill mix.
3. **Overtime.** Review it as a percentage of total salaries and trend it over time. At 150% of regular pay, it can increase your salary costs substantially. Reduce it by staggering shifts where possible, and requiring prior approval.
4. **Health insurance.** This continues to be a major expense for many practices. Savings are available from increasing deductibles and copays, increasing the employee's percentage of the premiums, going to a major medical plan, etc.

Rent and Utilities

While this category is relatively fixed, a medical building's lease rates are generally higher than other commercial buildings. Consider moving non-clinical activities off site to lower rent. Also, consider acquiring your own building if economics make sense.

Malpractice

In this area, you may wish to consider alternative quotations through your professional society, the MSMA, local PHO, etc. Additionally, competitive bidding and review of dollar limits may be options.

Drugs, Medical and Office Supplies

The issue of control may be more important here than price. While there may be the opportunity for volume purchasing discounts through one vendor, it is also advantageous to use two-three vendors, and compare prices. This category usually is

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not a significant expense to the practice. My greater concern is the controls over the usage and loss. Accordingly, controls should be developed to monitor use by area, including tracking costs over time and relationships between the medical and drug costs and related revenues.

Schedule A
Practice Overhead Comparison As Percentage of Collections

Description	Actual	Range Low	Range High
Salary & Benefits	25%	15%	22%
Rent and Utilities	8%	5%	6%
Malpractice	2%	2%	5%
Medical Supplies	3%	3%	5%
Office Supplies	2%	1%	4%
Depreciation	4%	3%	5%
Professional Services	1%	2%	3%
Continuing Education	2%	1%	3%
Dues & Subscriptions	1%	1%	1%
Travel & Entertainment	3%	1%	2%
Total	**51%**	**34%**	**56%**

NOTE: These ranges differ based on your specialty. The high and low ranges are for illustration purposes only.

Service Agreements

This is a major source of profits for the medical equipment manufacturers. My personal experience has been that the actual "full service" contract cost to the manufacturers is less than 50% of the service contract. While you must consider the specific age and service history of your equipment, you may wish to consider a local service company, a less than full service contract from the manufacturer, or "go bare," paying for time and materials on an "as needed" basis.

In House vs. Contract

While not an expense category as such, you should always be aware of the possibility of cost savings by contracting out non-clinical services. Activities such as payroll, accounting, insurance claims filing, data entry, collection calls, and transcriptions are candidates. You need to consider such issues as quality, control, speed of turnaround, etc.

Internal Controls

Another key factor in your practice is having a system of internal controls, i.e. "checks and balances" or "division of duties" to insure the practice is operating as desired. Key components should include:

1. Bonding of employees
2. Requiring vacations to be taken
3. Division of responsibilities among employees
4. Physician signing all checks
5. Balancing daily sheets/daily bank deposits
6. All invoices be stamped "PAID" and attached to check to be signed
7. Posting of cash receipts against A/R separate from opening the mail and making bank deposits.

Pension and Profit Sharing Plans

The practice should review the current plan(s) as to contribution levels, integration with social security and offering 401K options. Depending on relative ages of physicians and employees, a non-qualified plan for the physicians may be considered.

Financial Statements

Your financials are an excellent tool in the management of your practice costs. By reviewing the percentage of each expense to collections, comparing to averages and ranges for your specialty you can pin point areas for further study. By trending these relationships over several months, you can track your progress toward reducing overhead and increasing your cash! MoMed

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Putting Quality Improvement into (Your) Practice

Gregg R. Laiben, MD

"Quality assurance...TQM... quality improvement...CQI...what do these words and acronyms mean?...are they important?...do I have to worry about this...the QA Manager just called, now what do I have to do?..."

If this bewildering array of jargon strikes a chord, then read on. The medical community is being showered with information about performance measures, outcomes studies, process indicators, and other aspects of the quality improvement (QI) process. Despite the publicity devoted to the concepts referenced above, many physicians still remain confused and doubtful of the positive benefits that can result from incorporating QI changes into their own clinical practice. This is the first article in a series over the coming months to help clarify the concepts that industry, and now health care, are using on a daily basis to improve their final products. In the automobile industry, these techniques have been used by American manufacturers to regain credibility, reliability, and dependability in their product (cars). Likewise in medicine, similar processes are being used by hospitals, physicians, and other providers to improve our ultimate product, the care delivered to patients.

At the series' conclusion, the reader will have developed a clearer understanding of the terminology used and of the methods of the continuous quality improvement (CQI) process as it relates to medicine. Once understood, relatively simple CQI changes can be easily integrated into the office setting.

Firstly, we must understand what creates the demand for improvement in health care. The reasons are many and must be outlined to set the stage for understanding why the medical profession has adopted techniques once thought to be exclusive to the assembly line.

For clinicians, a strong professional ethic drives a desire to *do what is right*: to give patients prudent and wise care of the utmost quality. Part of assuring that care remains at a high level, the physician stays abreast of recent advances in medicine by ongoing education through various means like attending seminars, reviewing the current medical literature, performance of scientific research, peer discussions, etc. The knowledge gained from these endeavors is incorporated into the clinician's diagnostic and treatment skills, with the patient benefiting from updated skills and treatment processes.

Concurrent with the professional and ethical desire of physicians to practice high quality medicine, they are further encouraged to do so by both societal and individual requirements. The rise of consumerism throughout American society was advocated by individuals wanting better value for their hard-earned dollars. This value assessment translated into a desire for information about the product. However, much product information available at the time was subjective in nature, and therefore potentially biased. Purchasers felt they were not receiving acceptable value for their money when the only information provided was from the manufacturer or retailer, as both groups had financial incentives to overinflate the product's value. This public desire for objective information created an outlet for independent unbiased product evaluations. As a result, magazines like ***Consumer Reports*** appeared.

Presently, the health care industry is seeing a similar rise in desire for objective information about the health care delivery process. The same market forces that created the demand in retail product lines are unfolding in health care. Although surveys as recent as July 1996 from Princeton Survey

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Research Associates show that 57% of respondents indicated that family and friends exert "a lot" of influence in choosing a new health care plan, the same survey noted that 42% said that "quality" was the paramount concern in choosing a plan.

The profession must respond to the growing market force demand for objective and unbiased information about the care delivered by its members. Patients will then have a choice in their health care matters based upon informed decision making. Otherwise, the information available to the patient remains subjective, and therefore, potentially biased.

Although managed care is still primarily involved in a pricing-based phase of competitive strategy, the companies will not likely remain so. Plans currently adjust premium rates with a close eye on the competition in an effort to retain market share. Eventually, as the managed care industry matures and evolves in each locale, the rate-driven market advantage will disappear. A level of pricing will eventually be reached by all plans, at which no further significant decreases can be made without potentially dire consequences. At that point, the only difference between plans will be one of customer service. The primary element of customer service will be the quality of health care services provided. Not only does the care have to be excellent for the plan to remain competitive, the plan must notify its current and future patients of this fact through advertising, newsletters, and other public relations activities.

For those readers who doubt the above scenario, look no further than the pharmaceutical industry. Remember the profession's outcry when pharmaceutical manufacturers began their consumer-oriented approach to prescription drug advertisement. Generic forms of medication were keeping prices level or even driving brand name prices downward. ***Good Housekeeping***'s ads began to reflect the differences between the branded drug and its competitors, so that the readers, potential users of the drug, could comparison shop. Consumers were shown charts, tables, and graphs that were easily understood and which improved product sales.

Employers are also creating a need for improvement in health care. After all, they are the primary payors for a large amount of health services via their premium dollars. Lowered premium costs reflect directly upon and increase bottom line profits. Therefore, they are seeking to insure their employees with a plan that provides quality care at the lowest premium rate. Not only are direct profits improved by reduced expenditures for health coverage, but the indirect benefits include a healthier work force which improves efficiency, and therefore, profit.

Managed care organizations (MCOs) are now scrutinizing their physician provider panels very closely. No longer are physicians accepting carte blanche when submitting initial applications for privileges. Nor should they expect the periodic reappointment process to be automatic, which will likely include review of the doctor's past utilization practices.

The strong focus on utilization criteria will eventually lessen as the managed care market matures, and like premium pricing, will achieve steady-state levels in which more stringent utilization practices would produce repercussions in the quality of care. At that point, a shift in focus is likely to occur from utilization to quality of care as the primary means of assessing physician performance. When the plan recredentials its physicians, various items such as patient satisfaction surveys and objective measures of his/her delivery of quality health care will assume greater importance.

Another way to look at CQI is to envision it as the scientific method of experimentation, a concept intimately familiar to physicians.

Based upon the foregoing descriptions of the changes occurring in health care, the prudent physician needs to assess how he/she stands in relationship to peers and other practices. To believe the old idiom that a physician merely needs to hang up a shingle and patients will appear, is unwise in today's environment. The shingle will not be enough. A sign will always be helpful, but the forward-thinking physician will assess the

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practice with an eye toward how patients and plans perceive their health care. Since these groups want objective indicators of good care to render informed choices, they will seek it out. Therefore, physicians desirous of expanding their patient base or wanting assurances of provider panel privileges will find ways to supply the necessary requests.

The information sought by patients and plans is easily obtainable with the tools available to the practitioner today: the computer in virtually every physician's office is capable of sorting information and forming the basis for an informational database. This information can be readily combined with clinical details obtained from samples of medical records to provide a simple snapshot picture of one's practice. Further analysis using advanced analytical and statistical techniques can provide an even more accurate and clinically relevant description of practice patterns.

QI techniques in the office do not need to be complex or expensive to be effective. Methods as simple as surveying a portion of your patients can deliver useful information. To illustrate this, let's visit the office of Dr. I.M. Goode, a solo family practitioner in a small town 40 miles from Big City, Missouri.

Dr. Goode recently noticed a drop in office appointments and is concerned about his practice as Big City HMO has been advertising in the local paper. Since the decline began about two months ago he reviews his patient appointment logs for the previous six months to gather an adequate amount of information and to establish a baseline rate of daily patient visits. Dr. Goode enters the number of patients seen daily into his computer's spreadsheet program and creates a graph. Time is plotted along the graph's "X" axis and the number of patients seen daily along the "Y" axis. The graph shows an even line for the first three months at the 35-40 patients per day level. However, the line then slopes downward with an unusual trend: the line drops a bit at the beginning of each subsequent month, yet remains flat for the duration of the given month. The graph indicates that patients are leaving the practice in clusters at the beginning of each month suggesting that some may be enrolling in Big City HMO.

Dr. Goode decided to survey his remaining patients to better understand the problem. Some questions on his brief survey include whether the patient was aware of Big City HMO, would they join an HMO if it were less costly than their current insurance, would they prefer to see a local physician, and would they be more likely to join the HMO if Dr. Goode was a participating primary care physician.

Over the next week each patient seen at the office received a brief questionnaire upon check-in. Since the survey was short and required only "Yes" or "No" answers, the normal practice routine was maintained. After the week of surveying, Dr. Goode tallied the answers and learned that indeed his patients were concerned about their premium costs but would also prefer to continue seeing Dr. Goode. Based upon the survey results, he applied for panel privileges at the HMO and was accepted.

The foregoing scenario is very simplistic but is a very practical application of CQI. Each step undertaken by our fictitious practitioner can be described in the CQI cycle. Dr. Goode identified the problem when he noticed the decrease in patient visits and planned further investigation. He established a baseline of the daily visit rate by abstracting data from the appointment logs. The office computer allowed him to graph the data so that the information was easier to analyze and to observe for trends. Confirming the problem of the patient exodus, he collected additional information by conducting the survey to help find a solution to his problem. He then implemented an action plan based upon the results of the information (joining the HMO physician panel). Dr. Goode will now wait a period of time for his action to have an impact and will remeasure patient visits to determine success.

The identification of areas of medical practice ripe for improvement is only one of the many CQI techniques available to assist the practitioner. Integrating other CQI concepts will allow for development of a process to improve care and enable subsequent reassessment to determine if the appropriate changes have occurred. If this concept seems familiar, do not be surprised. Another way to look at CQI is to envision it as the scientific method of experimentation, a concept intimately familiar to physicians. In the next installment I will explore CQI further and identify other simple tools you can use to improve patient care. **MoMed**

The Author

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A Guide to Prescribing, Administering and Dispensing Controlled Substances in Missouri

Edited by
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A Guide to Prescribing, Administering and Dispensing Controlled Substances in Missouri

The abuse of prescription drugs, especially controlled substances, is a serious social and health problem in Missouri and the United States. As a practitioner, you share responsibility for solving the prescription drug abuse and diversion problem.

You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.

You have a professional responsibility to prescribe controlled substances appropriately, guarding against abuse while ensuring that your patients have medication available when they need it.

You have a personal responsibility to protect your practice from becoming an easy target for drug diversion, which could result in legal actions against you and loss of your professional license. It is not the intent of these guidelines to limit or deny the access of legitimate patients to controlled substance medications of recognized and appropriate therapeutic value.

You have a legal responsibility to acquaint yourself with the state and federal requirements for the prescribing and dispensing of controlled substances. Should you fail to abide by the requirements, you are subject to the loss or restriction of controlled substances privileges and discipline by the appropriate professional state licensing board.

This guide will help you meet these responsibilities. It summarizes key aspects of Missouri and federal controlled substances law and outlines common sense procedures that practitioners can use to prevent diversion of these drugs from their practice.

Registration Information

Practitioners who prescribe, administer or dispense controlled substances shall be registered with both the state and federal governments. The federal Drug Enforcement Administration (DEA) registration must be renewed every three years. The certificate of registration must be kept available for inspection at the registered location. The Missouri Bureau of Narcotics and Dangerous Drugs (BNDD) requires an annual registration for practitioners.

For the purpose of this guide, practitioners include those licensed individuals who are authorized by state statute to prescribe, administer or dispense controlled substances.

If a practitioner maintains a controlled substance stock at more than one office, the practitioner must register at each office.

BNDD and DEA must be notified in writing (preferably

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within 6-8 weeks) before any change of practice location occurs; otherwise, the practitioner's registration becomes void upon the change of location and the practitioner may no longer legally prescribe, administer, dispense or possess controlled substances.

What are Controlled Substances and Who "Controls" Them?

A controlled substance is a drug or drug product that comes under the jurisdiction of the federal Controlled Substances Act of 1970. The narcotic, depressant, stimulant, hallucinogenic and anabolicsteroid drugs that are covered by the Controlled Substances Act (CSA) are listed in one of five schedules. Schedule I substances have no accepted medical use in the U.S. and have high abuse potential. Schedule II drugs have high abuse potential with severe psychic or physical dependence liability, and in general are substances that have therapeutic utility. Schedules III, IV, and V include drugs with decreasing levels of abuse potential. Representative examples listed below are by common name or generic name, and some are accompanied by a common trade name in parentheses. There are some differences between federal and state listings of controlled substances.

The Comprehensive Drug Control Act of 1989, administered by the Bureau of Narcotics and Dangerous Drugs in the Missouri Department of Health, closely parallels the federal law. In some instances, however, Missouri's law is more stringent and takes precedence over federal law. For example, in Missouri, narcotic-containing cough syrups and certain ephedrine products are listed in Schedule IV and cannot be purchased without a prescription.

Missouri has established a diversion control and prevention program, coordinated among state and federal agencies, to identify and stop diversion. BNDD regularly evaluates drug purchases and other information and then reports suspected or potential diversion to the licensing agencies. These agencies further evaluate violations of law or standards of professional conduct, and proceed accordingly.

What Constitutes a Legitimate Prescription for a Controlled Substance?

Federal and state regulations clearly specify legitimate purposes for prescribing controlled substances:

A prescription for a controlled substance is effective only if it is used for a legitimate medical purpose by a practitioner acting in the usual course of professional practice.

Three criteria must be met:

1. The patient must desire treatment for a legitimate illness or condition.
2. A practitioner must establish a legitimate need through assessment, utilizing pertinent technical diagnostic modalities.
3. There must be reasonable correlations between the drugs prescribed and the patient's legitimate needs.

The Intractable Pain Act, passed in 1995, provides guidelines for the treatment of chronic, intractable pain. This law was intended to clarify the parameters for treating chronic pain with controlled substances. The physician must document the diagnosis and treatment of chronic pain in the patient record and the use of controlled substances must be therapeutic in nature and the manner utilized. Physicians may not prescribe or dispense controlled substances to a patient for chemical dependency unrelated to intractable pain or to a patient who the physician knows, or should know is using the medication in a nontherapeutic manner. Physicians may be subject to disciplinary action for nontherapeutic use of controlled substances, failing to keep accurate on-going treatment records, failing to keep complete and accurate controlled substance records, writing false or fictitious prescriptions, or prescribing controlled substances in a manner inconsistent with state or federal drug laws.

Practitioners may not issue a prescription to obtain controlled substances for dispensing to patients. Practitioners must use DEA form 222 to obtain Schedule II controlled drugs. The supplier must issue a receipt invoice for Schedule III, IV and V drugs purchased.

Controlled drugs for a practitioner's personal use should be prescribed by another appropriate practi-

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Schedules of Controlled Substances

Common Examples

SCHEDULE I - Drugs cannot be prescribed except in special research situations. There is no accepted medical use.

- fenethylline
- peyote
- heroin
- LSD
- marijuana
- mescaline
- MDMA
- methaqualone
- DMA

SCHEDULE II - Maximum 30-day supply for any one prescription, no refills.* No phoned prescriptions except in emergency.

Schedule II Narcotic

- morphine (Roxanol, MS-Contin)
- fentanyl (Sublimaze)
- hydromorphone (Dilaudid)
- methadone (Dolophine)
- oxymorphone (Numorphan)
- opium
- diprenorphine (M50-50)
- etorphine (M99)
- cocaine
- butyl nitrite (Rush)
- codeine
- sufentanil (Sufenta)
- meperidine (Demerol)
- oxycodone (Roxicodone, Percodan, Tylox)
- LAAM
- anileridine (Leritine)

Schedule II Non-Narcotic

- dextroamphetamine (Dexedrine)
- methamphetamine (Desoxyn)
- methylphenidate (Ritalin)
- phenmetrazine (Preludin)
- amobarbital (Amytal)
- pentobarbital (Nembutal)
- secobarbital (Seconal)
- dronabinol (Marinol)
- nabilone (Cesamet)
- phencyclidine (PCP)
- glutethimide (Doriden)

SCHEDULE III - Maximum 90-day supply, maximum five refills within a six-month period.* Phone prescriptions allowed.

Schedule III Narcotic

- codeine (Tylenol w/codeine, Fiorinal w/codeine)
- dihydrocodeine (Synalgos (DC)
- hydrocodone (Tussionex, Hycodan, Vicodin)
- opium (paregoric)

Schedule III Non-Narcotic

- butalbital (Fiorinal)
- thiopental (Pentothal)
- pentobarbital(Beuthanasia-D Special)
- methyprylon (Noludar)
- fluoxymesterone (Halotestin)
- phendimetrazine (Plegine,Bacarate)
- testosterone
- methyltestosterone (Oreton)
- benzphetamine (Didrex)
- nandrolone (Deca-Durabolin)

SCHEDULE IV - Maximum 90-day supply, maximum five refills within a six-month period. Phone prescriptions allowed.

- ephedrine
- pentazocine (Talwin)
- chlordiazepoxide (Librium)
- clorazepate (Tranxene)
- flurazepam (Dalmane)
- fenfluramine (Pondimin)
- flunitrazepam (Rohypnol)
- barbital
- chloral hydrate
- meprobamate (Equanil)
- diethylpropion (Tenuate)
- lorazepam (Ativan)
- temazepam (Restoril)
- zolpidem (Ambien)
- mephobarbital (Mebaral)
- alprazolam (Xanax)
- clonazepam (Klonopin)
- diazepam (Valium)
- pemoline (Cylert)
- dexfenfluramine (Redux)
- dextropropoxyphene (Darvon, Darvocet)
- methohexital (Brevital)
- ethchlorvynol (Placidyl)
- paraldehyde
- mazindol (Sanorex)
- midazolam (Versed)
- triazolam (Halcion)
- codeine (Robitussin DAC, Terpin hydrate phenobarbital w/codeine)
- phentermine (Ionamin, Fastin, Adipex-P)

SCHEDULE V - Maximum 90-day supply, maximum five refills within a six-month period. Phone prescriptions allowed.

- buprenorphine (Buprenex)
- diphenoxylate (Lomotil)

EXEMPTED AND EXCLUDED SUBSTANCES

- butalbital (Fioricet)
- phenobarbital (Cafergot PB, Tedral)
- chlordiazepoxide (Librax)
- 1-deoxyephedine (Vicks inhaler)

NONCONTROLLED FREQUENTLY ABUSED DRUGS

- nalbuphine (Nubain)
- butorphanol (Stadol)
- dezocine (Dalgan)
- carisoprodol (Soma)
- ketamine (Ketalar)
- tramadol (Ultram)

*See page 80.

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tioner, on the basis of an established practitioner/patient relationship. Physicians are prohibited by law from prescribing, dispensing or administering controlled drugs to themselves.

It is recommended that practitioners do not prescribe, dispense or administer controlled drugs to office staff or family members. These activities may be investigated by both the appropriate professional state licensing board and BNDD. For dentists, veterinarians, podiatrists and optometrists certified to use therapeutic pharmaceutical agents licensed by their respective professional boards, the prescribing, administering, dispensing or distribution of controlled substances is limited to the scope of their respective professional practice after establishment of a practitioner/patient relationship. If the practitioner does prescribe, dispense or administer to office staff or family members, these individuals must be treated in the same manner as regular patients. This includes maintaining a chart, listing a diagnosis, plan of treatment and prognosis, and using the same documentation and care as with regular patients.

Prescriptions may not be issued to dispense narcotic drugs for detoxification or maintenance treatment of a person who is dependent on narcotic drugs. However, a practitioner may administer (but not prescribe) narcotic drugs to a patient daily for up to three days while arrangements are being made for referral to an existing narcotic treatment program.

How Do You Issue a Legal Prescription?

Prescriptions for controlled substances must be dated and signed on the day issued. A prescription also must include the following information:

- ✔ Name and address of the patient, including street and city
- ✔ Name, address and DEA registration number of the practitioner
- ✔ Signature of the practitioner
- ✔ Name and quantity of drug prescribed
- ✔ Directions for use

It is the practitioner's responsibility to provide this information. It is the pharmacist's responsibility to verify that it is properly provided.

Practitioners who prescribe Schedule II controlled substances must now maintain a record of all such prescriptions, either in the patient's chart or in a separate log. If the patient's chart is used, all Schedule II prescription information must be highlighted in some manner so as to be readily retrievable.

If a separate log is maintained for Schedule II prescriptions, which is highly recommended, the record should include the date, full name and address of the patient, the drug name, strength, dosage form, and quantity.

While Schedule III, IV and V controlled substance prescriptions are currently not required to be entered in the patient chart, it is strongly recommended that all prescription and refill information be entered in the chart to confirm that controlled substance prescriptions were written.

What Procedures and Records are Necessary for Dispensing and Administering?

The practitioner must provide direct supervision to employees who assist in dispensing. Dispensing cannot occur unless the practitioner is physically in the registered location, except when a registered nurse is dispensing under a collaborative practice agreement.

Under a collaborative practice agreement with a physician, a registered nurse may administer or dispense controlled substances within the nurse's scope of practice and consistent with the nurse's skill, training and competence. The nurse may not prescribe controlled substances. The nurse may obtain a Missouri Controlled Substances Registration, although it is not required and does not permit additional activities, but may not obtain a DEA registration. The collaborative practice physician must maintain BNDD and DEA registrations at the collaborative practice site and is responsible for all controlled substance activities, including purchasing controlled substances and authorizing receipt of controlled substance samples.

Drugs dispensed must be packaged in child-resistant containers and must be labeled with the date, the name and address of the practitioner, the name of the patient, the drug's name and strength, and directions for use.

Records must be maintained for two years for

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State and Federal Limitations on Prescriptions for Controlled Substances

Note: Many limitations are more stringent for Schedule II prescriptions.

Prescription Characteristic	Limitation Schedule II	Limitation Schedule III, IV and V
Mode of issuing prescription	Written or fax* (except in a bona fide emergency)**	Verbal, written or fax*
Refills	None allowed C partial filling allowed for terminal patients in long-term care facilities	Maximum of five within six months of issuing prescriptionor patients
Length of prescription validity	One year	Six months
Quantity limitations***	30 days	90 days

*Written, signed prescriptions may be transmitted by fax. When the drug is in Schedule II the original prescription must be presented to the pharmacist before dispensing, except when the prescription is for a long-term care facility resident or for certain narcotic injectable preparations. The face of the original prescription for all schedules must be signed and dated after transmission and the prescription filed chronologically at the practitioner's office, except when the original Schedule II prescription must be presented to the pharmacist.

**Emergency means that the immediate administration of the drugs is necessary for proper treatment, that no alternative treatment is available, and it is not possible to provide a written prescription order for the drug at that time. In the case of a bona fide emergency, a practitioner may telephone a prescription order to a pharmacist for a controlled substance in Schedule II. In such a case, the drug prescribed must be limited to the amount needed to treat the patient during the emergency period. Within 72 hours, the practitioner must furnish to the pharmacy a written, signed prescription for the controlled substance prescribed. The pharmacist is required by law to notify DEA and BNDD if a written prescription is not received within 72 hours.

*** These quantities can be increased to a six-month supply if the physician describes on the prescription form the medical reason for requiring the larger supply.

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all controlled substances received, dispensed, administered or otherwise disposed of, including invoices, return receipts, dispensing, administration and destruction records.

A dispensing log must be maintained separate from the patient's medical record and must include:

- Complete patient name
- Complete patient address, including city
- Drug name, strength and dosage form
- Quantity dispensed
- Date dispensed
- Name or initials of person dispensing

A recommended dispensing/administration form is available from BNDD.

Administration records must contain the same information as dispensing records. Although they may be kept in the patient's medical record, they must be readily retrievable. It is recommended they be kept on the dispensing/administration log.

A complete inventory must be recorded every two years. A continuous (perpetual) inventory is recommended and can be conveniently maintained as part of the dispensing/administration log for each drug.

Records must be kept of controlled substances transferred or distributed to other practitioners or other office locations. A license from the Missouri State Board of Pharmacy may be required in certain situations.

Expired or unwanted controlled substances may not be destroyed by the practitioner except in special circumstances when permission is granted by DEA. They may be returned to the original supplier using DEA Form 222 for Schedule II or a proper record of transfer for Schedules III-V. They may also be transferred to a DEA Registered "reverse distributor" company. A list of these companies is available from BNDD or DEA. Partially used dosage units such as syringes and ampules may be destroyed if the destruction is witnessed and documented by two persons.

Controlled substance samples must be treated in the same manner as any other controlled substance, including receiving, inventory, dispensing and destruction records. Procedures for packaging and labeling when dispensing must be followed.

If more than one practitioner in the same office receives controlled substances (including samples) under separate DEA registrations, all records and supplies must be maintained separately. Contact BNDD for procedures to combine records and supplies under a primary practitioner in group practice situations.

Where Should Controlled Substances Be Stored?

Under federal law, practitioners must store controlled substances in their offices or clinics in a securely locked, substantially constructed cabinet or safe. Access to the storage area should be restricted to persons specifically authorized to handle controlled substances.

Any loss or theft of controlled substances or DEA order forms must be reported to DEA and BNDD. Contact BNDD at 573-751-6321 for loss reporting forms. Thefts of controlled substances should be reported to local police. MoMed

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HIV-Infected Health Care Workers: The Disclosure Dilemma

Todd W. Amrein, JD

As of June 30, 1996, over half a million AIDS cases had been reported in the U.S. to the Centers for Disease Control (CDC).[1] Of those adults reported with AIDS, approximately 18,000 were employed in the health care field.[2] While there have been only six documented cases of HIV transmission from health care worker (HCW) to patient,[3] the CDC estimates that between 13 and 128 patients were infected with HIV from HCWs during invasive procedures[4] between 1981 and 1990.[5] This lack of certainty surrounding the frequency of transmission of HIV in the health care field has prompted many patients to demand disclosure of HCW serostatus.[6]

In July 1991, the CDC published *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures* ("CDC Guidelines"),[7] which embodies the CDC's position on HCW-to-patient transmission of HIV. In its study, the CDC determined that HIV-infected HCWs who adhere to "universal precautions"[8] and who do not perform invasive procedures pose no risk of HIV transmission to their patients.[9] However, it also recommended that HIV-infected HCWs should not perform exposure-prone procedures[10] unless they have first sought counsel from an expert review panel. According to the CDC, that panel should advise infected HCWs of the circumstances under which they may continue to perform exposure-prone procedures; one such circumstance recommended by the CDC includes *"notifying prospective patients of the HCW's seropositivity before they undergo exposure-prone invasive procedures."*[11] While Missouri has adopted portions of the CDC Guidelines, it does not require HIV-infected HCWs to disclose their seropositive status to their patients.[12]

Courts have long held that, in order to avoid liability, the physician must provide the patient with adequate information to make an intelligent decision regarding treatment and the risks involved in such treatment.[13] This doctrine of informed consent, however, only requires that the physician disclose "material" risks. Courts use two different standards to determine the materiality of the risk involved. The majority of courts adhere to the "professional standard," essentially based on what a reasonable practitioner would do under the same or similar circumstances.[14] These courts tend to believe that the physician is more qualified than the courts or laypersons to make decisions about proper disclosure.[15] A minority of courts follow the "patient-oriented standard," which requires the physician to disclose all information that a reasonable person *in the patient's circumstances* would find material to a treatment decision.[16] Surveys indicate that a large majority (95%) of individuals feel that a physician's infection with HIV should be disclosed to the patient.[17]

If the courts intend to employ the informed consent doctrine as a means of requiring HIV-positive HCWs to disclose their status, they will be using it in an entirely new way. Informed consent is traditionally applied in the health care context to require doctors to provide patients with information about the *procedure* the doctor intends to perform.[18] Courts generally have not extended it to compel HCWs to supply patients with a comprehensive list of their own mental or physical conditions.[19]

Recent court cases suggest, however, that this trend may change with the introduction of AIDS. For instance, in the case of *Behringer v. Medical Center at Princeton*,[20] a hospital adopted an official policy that allowed an HIV-infected surgeon to continue to practice medicine as a member of its

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staff, but refused to permit him to perform invasive procedures unless he disclosed his HIV-positive status to his patients. As a result, he never again practiced surgery at the hospital. The surgeon filed suit, alleging that informed consent law did not mandate disclosure of his condition, and that patient reaction to the information would be based on hysteria rather than on a rational consideration of the risks. The court held that the necessity of informed consent outweighed any harm to the surgeon, stating "[i]f there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon, the arbiter will be the fully-informed patient."[21]

In another case, *In re Application of the Milton S. Hershey Medical Center of the Pennsylvania State University*,[22] the court favored limited disclosure,[23] where an HIV-positive surgical resident sustained a cut during an invasive procedure. The court held that public health interests outweighed the privacy interests of the resident, declaring that *"Dr. Doe's medical problem was not merely his. It became a public concern the moment he picked up a surgical instrument and became part of a team involved in invasive procedures."*[24]

These cases have ignited the debate over whether HIV-positive HCWs have an obligation to disclose their condition to their patients. While patients generally desire to know if HCWs are infected with HIV prior to seeking treatment, the medical community opposes such disclosure.

According to disclosure opponents, application of the informed consent doctrine in this area is unwarranted because HIV-positive HCWs present such a low risk of infecting patients that their condition is not "material" and therefore need not be disclosed.[25] In addition, mandatory disclosure would constitute an invasion of privacy. HCWs fear discrimination and other adverse consequences that may result if their seropositive condition is disclosed.[26] For instance, HCWs contend that their careers would be ruined if they are forced to disclose such information.

Supporters of disclosure respond with several arguments. First, the uncertain frequency of HIV transmission from HCW to patient presents a material risk, and they view the patient-oriented standard for informed consent as more appropriate than the professional standard. According to them, an HIV-positive surgeon deciding whether to disclose his status and "ruin his career" or to keep the information private and continue performing surgery present the ultimate conflict of interest. Second, most disclosure proponents advocate that only those HIV-infected HCWs conducting invasive, exposure-prone procedures should have an obligation of disclosure to their patients. Finally, HCWs who claim disclosure violates their right to privacy have lost sight of what should be their most important objective: to act in the best interests of their patients.

As the debate continues, the public will have to trust members of the medical profession to do what is best for their patients. In testifying before Congress in 1991, one physician said: "[P]hysicians should be the leaders in determining their HIV status. As a profession, we need to hold ourselves up to a high standard. Remember, Hippocrates said, 'First, do no harm.'"[27]

The CDC has acknowledged the risk of HCW-to-patient transmission of HIV, and cases of such transmission have been documented. However, disclosure of HIV-positive serostatus serves as a genuine threat to physician practices, resulting in a substantial conflict of interest. Although Missouri has adopted the CDC Guidelines in some measure, it does not mandate disclosure of an HCW's seropositivity, and participation by an HIV-infected HCW in the evaluation process is currently voluntary.[28]

For now, Missourians must rely upon physician discretion and trust that the Hippocratic Oath will compel HCWs to determine their HIV status and, if positive, to disclose that status to their patients before performing invasive, exposure-prone procedures.

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6. Barbara Kantrowitz et al., Doctors and AIDS, Newsweek, July 1, 1991, at 49-50.
7. 40 Morbidity & Mortality Wkly. Rpt. 1 (Supp. RR-8, July 12, 1991).
8. "Universal Precautions" recommend the use of appropriate barrier protection by HCWs and the use of procedures that would prevent injuries caused by needles, scalpels, and other sharp instruments.
9. CDC Guidelines, supra note 7, at 2.
10. The CDC defined "exposure-prone procedure" as "digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site." Id. at 4.
11. Id. at 5-6 (emphasis added).
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The Author

Todd W. Amrein earned his B.A. from Emory University in 1993 and his J.D. from the University of Missouri-Columbia in 1996. A native of St. Louis, he currently resides in Springfield, Missouri, where he serves as law clerk to Judge Phillip R. Garrison of the Missouri Court of Appeals.

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AIR FORCE

OMSS Reports from AMA I-96

by Peggy Barjenbruch, MD

The American Medical Association Organized Medical Staff Section (AMA-OMSS) met during the AMA's Interim Meeting in December. The meeting afforded organized medical staff representatives of hospitals and other health care facilities, delivery systems, and organizations the opportunity to develop policy positions on issues, share experiences/perspectives, and learn approaches for improving medical practice and patient care.

The AMA-OMSS considered 16 resolutions and 12 Governing Council reports. Two items were referred to the Governing Council. All resolutions forwarded to the AMA House of Delegates (HOD) and seven OMSS recommendations to the HOD were adopted, some with minor modifications. Peggy Barjenbruch, MD, MSMA-OMSS Delegate to the AMA, was present at the Interim Meeting and served on Reference Committee A and was instrumental in formulating the eight resolutions which are listed below along with other meeting highlights.

AMA Policy Action

Data Bank Self-Query. Asks that the AMA use any necessary effort, including legislative relief, to confirm that the National Practitioner Data (NPDB) information be released only to authorized entities, and that physicians not be required to self-query the NPDB for purpose of re-disclosure of their reports to unauthorized entities. Further, while these efforts are ongoing, the AMA should alert physicians to be aware of the problems of re-disclosure of the NPDB information to unauthorized entities, and widely disseminate a protective sample "letter of agreement" which could be used by the physician to assure that unauthorized disclosures are prohibited.

Health Care Plan Information on the Internet. Asks that the AMA investigate developing a site on its Internet Home Page that provides useful information about health plans to include: (1) guidelines for selecting plans and deciphering report card data, (2) relevant information on plan finances, capitation, salaries, treatment and care, gag clauses, contract provisions, and (3) linkage to other pertinent Web sites. Further, that the AMA serve as the architect, with assistance from the Federation, to design a template for use by state, county, and large urban medical associations, in uploading health plan information deemed useful to patients and their employers for informed decision-making on the World Wide Web.

Lack of Federal Peer Review Confidentiality Protection. Asks that the AMA seek to vigorously pursue enactment of federal legislation to prohibit discovery of records, information, and documents obtained during the course of professional review proceedings.

Bounty Hunter Provision of the Health Insurance Portability and Accountability Act of 1996. Asks that the AMA work toward amending the Health Insurance Portability and Accountability Act of 1996 by imposing civil monetary penalties for fraudulently and falsely reporting physician fraud and, further, that the AMA closely monitor the activities of all agencies engaged in investigating and prosecuting these fraud cases and report back to the AMA House of Delegates at its Interim 1997 meeting.

AMA Entering the Broad Based Tax Reform Debate. Asks that the AMA prepare to enter into probable future Congressional hearings, debates, and legislation concerning broad tax reform that might impact the U.S. health care delivery systems.

Managed Care Organization - Credentialing. Asks that (1) the AMA establish policy that hospital medical staff privileges not be required for physician participation in managed care contract panels, (2) managed care entities should have an effective, physician directed peer review mechanism to fairly evaluate their participating physicians, and (3) the AMA distribute this policy to associations and organizations representing managed care entities.

Hospital Employed/Contracted Physicians Reimbursement. Asks that (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts and be informed about the actual payment amount allocated to the physician component of

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the total hospital payment received by the contractual arrangement; (2) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians and (3) the AMA advocate this policy to the American Hospital Association (AHA) and strongly encourage the AHA to communicate the policy to all of its member hospitals.

Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators. Asks that the AMA condemn any action taken by administrators or governing bodies of hospitals or other health care delivery systems who act in an administrative capacity to reduce or withdraw or otherwise prevent a physician from exercising professional privileges because of medical staff advocacy activities unrelated to professional competence, conduct or ethics. In addition, the AMA seek endorsement of this position by the American Hospital Association.

OMSS Action

Governing Council Report, "Mergers and Acquisitions" provided the impetus for the recommendations found in Board of Trustees Report, "Activities of the Joint Commission on the Accreditation of Healthcare Organizations," which were adopted at the Interim Meeting. AMA policy now states that one or more organized, self-governing medical staffs have overall responsibility for the quality of professional services provided by individuals with clinical privileges at the hospital, as well as accountability to the governing body. In addition, medical staffs should be involved in at least the following activities during a merger, consolidation, or affiliation; a) defining the role and structure of the medical staff(s), b) development and approval of medical staff bylaws, c) defining and approving credentialing processes, d) quality improvement, peer and utilization review activities, and e) decisions regarding clinical services to be offered by the institutions. AMA will work to have this policy become a new Joint Commission medical staff standard. MoMed

Proposed MSMA Constitution Changes

The following proposed changes in the MSMA Constitution were presented at the 1996 meeting of the House of Delegates and will be voted on during the 1997 Annual Convention.

Article ~~IV~~ III. House of Delegates

Article ~~V~~ IV. Council. The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, the duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physician Section, and the ~~Hospital~~ Organized Medical Staff Section. A majority of voting members of the Council shall constitute a quorum.

Article ~~VI~~ V. Council on Ethical and Judicial Affairs

Article ~~VII~~ VI. Sessions & Meetings

Article ~~VIII~~ VII. Officers. Section 2. The Officers shall be elected annually. The term of Councilors and Vice-Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor, and ~~hospital~~ organized medical staff Councilor, who shall each be elected to a one-year term. The Delegates from the Medical Students Section, the Resident Physicians Section, and the ~~Hospital~~ Organized Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor.

Article ~~IX~~ VIII. Funds, Expenses and Budget

Article ~~X~~ IX. Referendum

Article ~~XI~~ X. Seal

Article ~~XII~~ XI. Amendments. The House of Delegates may amend any article of the constitution by a two-thirds vote of the delegates present and voting in any Annual Convention, provided that such amendment shall have been ~~presented in the previous open meeting of the House of Delegates and that the amendment shall have been~~ published twice during the year in the Journal of the Association or sent officially to each component society at least two months prior to the meeting at which final action is to be taken.

Farewell to the Young Physicians Section

Robert Schaaf, MD

“Every man over forty is a scoundrel,” said George Bernard Shaw.

Oliver Wendell Homes said, “To be seventy years young is sometimes far more cheerful and hopeful than to be forty years old.”

I say, “Since I have to leave the Young Physicians Section, because I turned forty, does that now mean I’m an old physician?”

The answer, of course, is “Yes, since I am past my first five years in practice.”

Now that age hath stolen my YPS membership, there is a spot for you!

But if you, the reader, are under forty or in those ‘first five,’ you are automatically a member of YPS, and still ‘young.’ The question to you is “Are you making the most of your automatic membership?”

The YPS is active on the state and national levels, and I have been privileged to represent MSMA as YPS Delegate to the AMA. The meetings are held twice yearly two days before the AMA meets to allow time for YPS to formulate resolutions for the full AMA House to consider. Most recently, I went to the Interim Session in Atlanta, where we considered issues such as ‘Restrictive Covenants During Training,’ ‘Coverage for Medically Necessary OTC Medications,’ ‘Caring for the Working Poor and Their Dependents,’ and ‘Denial of Payment for Precertified Care.’ The AMA ratified YPS resolutions on each of these issues.

The AMA also is studying YPS resolutions on ‘Community Mobility Device Prescription’ and ‘Physician Supply and Antitrust.’ The AMA will, as the result of a YPS resolution, where and when feasible, provide recycling bins for white paper at AMA meetings.

Alas, now that I am a scoundrel, they won’t have me any more. No more lively debate with other young physicians at the YPS House of Delegates. No more legislative update luncheons with the AMA lobbyists. No more rubbing shoulders with other doctors who share some of the same problems and are working together to solve them.

Now that age hath stolen my YPS membership, there is a spot for you! If you are interested in filling this position, attend the YPS meeting in conjunction with the MSMA Annual Convention and let everyone know you would like to represent the YPS.

Also during the Annual Convention, you will be able to discuss issues which are very important to you as a young physician. The group may want to send some hot issues to the AMA YPS through the Delegates. So you see, you can get a resolution sent to the AMA for consideration of your important issues through this little known pathway.

As a YPS Delegate, you can attend the reference committee meetings of the AMA House of Delegates and testify on the resolutions.

As you can see, there are many reasons why you should be active in YPS, to which you automatically belong. So take advantage of your youth!

Restrictive Covenants During Training

The AMA House adopted an AMA-YPS resolution strongly

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urging that residency and fellowship training programs which utilize restrictive covenants provide written intent to impose restrictions in advance of the interview process. The resolution also urges the Council on Ethical and Judicial Affairs to consider strengthening its current opinion against restrictive covenants, including elimination of restrictive covenants for residents and fellows.

Coverage for Medically Necessary OTC Medications

AMA Delegates concurred with a YPS resolution calling for an AMA study on the problem of patient reimbursement from health care plans for appropriate medically necessary over-the-counter medications, disposable medical equipment, or durable medical equipment, with a prescription from their physician. The study will address such issues as the exacerbation of illness when patients are unable to afford medically necessary treatments; patients' pressure on doctors to prescribe certain prescription medications when over-the-counter medications are more appropriate; increased paperwork and administration time on the physician; the potentially onerous burden of certifying as to the medical necessity of nonprescription medications; potential cost-shifting; and possible increased numbers of patient visits.

Caring for the Working Poor and Their Dependents

The House voted to ratify this YPS resolution asking that the AMA explore the development of partnerships with corporations, nonprofit organizations, and state and local governments to address the needs of the working poor and their dependents. The AMA will widely disseminate the lessons learned from the study.

Community Mobility Device Prescription

Delegates referred to the AMA Board this resolution asking the AMA to work toward statutory changes that will result in the Health Care Financing Administration allowing reimbursement for electronic platform mobility devices for patients who have achieved household mobility through rehabilitation, but who are still limited in their community mobility. This anomaly is the result of conflicting federal requirements.

Denial of Payment for Precertified Care

Thanks to adoption of an AMA-YPS resolution by AMA Delegates, this resolution modified reads as follows: The AMA supports legislation and/or regulation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization, unless fraud was committed or incorrect information provided at the time such prior approval was obtained.

Physician Supply and Antitrust

This AMA-YPS resolution was referred to the AMA Board for decision. It asked the AMA to support and/or initiate policies recognizing that there is currently an oversupply of physicians in some specialties and in some regions, and in the future there may be an oversupply across specialties and regions. It also encouraged medical schools to align medical school class sizes with current and future physician supply requirements. Finally, it asked the AMA to seek appropriate antitrust relief so organized medicine may work to better regulate physician supply. MoMed

Wanted:

Creative Physicians
to submit articles,
editorials, photographs,
artwork, etc., to your
medical journal,
Missouri Medicine.

AMA Resident Section Meets in Atlanta

Howard Pomeranz, MD

The 20th Interim Session of the AMA Resident Physician Section (RPS) Assembly took place December 6-7, 1996 in Atlanta. Representing the Missouri State Medical Association Resident Physician Section were Howard Pomeranz, MD; Mary Vest-Mason, MD; Robert Phillips, MD; Sam Page, MD; Mark Schabbing, MD; Christian Hinrichs, MD, and Marsha McBride, MD. The Interim Assembly meeting was devoted to several items of business including the discussion of 24 resolutions and several RPS Governing Council reports as well as two elections. The following is a brief synopsis of resolutions and reports of interest to resident physicians.

1) Adopted a resolution supporting the continued involvement of physicians and educators in the development of a television rating system that is practical, developmentally appropriate, and based on existing research and scientific knowledge.

2) Adopted a resolution for the RPS to study the efficacy, cost, and financial responsibility for chemoprophylaxis in the event of exposure of a resident or medical student to blood borne pathogens.

3) Adopted a resolution asking the AMA to study the impact of the purchase and possession of needles and syringes without a prescription.

4) Adopted a resolution asking the AMA to encourage the FAA to report on medical emergencies that occur on U.S. air carrier domestic and international flights and that the AMA review the content of U.S. airline emergency kits and recommend appropriate upgrade of these kits.

5) Two resolutions regarding the subject of graduate medical education were referred to the RPS Governing Council: 1) to study the effect of redistribution or reduction of residency positions on resident work hours; and 2) to support payor reimbursement to the supervising physician for services provided by a resident unless that resident's service is fully and explicitly funded by the payor.

6) The RPS asked for the restoration of full funding for all years of training of combined residency programs and to seek reinstatement of full Medicare direct graduate medical education funding to training institutions for residents who have completed the minimum years of training for first board eligibility and are seeking a residency in primary care or other shortage specialty, as defined by HCFA. The RPS also asked for the restoration of direct graduate medical education funding that allows each resident an initial residency period of five years regardless of specialty choice or minimum years to attain board certification.

7) Adopted the following recommendations of a RPS Governing Council report on funding graduate medical education (GME):

A) The RPS support the use of an all-payor system to finance GME:

B) The RPS support the establishment of a portable voucher system for all US graduates to finance GME, and

C) The RPS support the use of a limit number of vouchers to finance GME for graduates of international medical schools.

An educational session "Medicine and the Information Revolution" was presented on Dec. 6, 1996, and showed the growth of medical informatics, using hospital computer systems to demonstrate storage and patient medical databases.

Several members of the Missouri Delegation were particularly active on councils or committees at the Interim Meeting. Mary Vest-Mason, MD, served on a RPS Reference Committees that heard testimony on resolutions and drafted recommendations for the RPS Assembly. Robert Phillips, MD, and Sam Page, MD, are serving as resident members of the AMA Council on Medical Education and the AMA Council on Legislation, respectively.

Marsha McBride, MD received an AMA/Glaxo Wellcome Leadership Award. Dr. McBride helped found the Health Resource Center, a free medical clinic for indigent patients in St. Louis.

Any resident physician or fellow in Missouri is encouraged to become active in the MSMA Resident Physician Section. For further information regarding the section or membership in the MSMA, contact the medical society at 573-636-5151.

The author, Howard Pomeranz, MD, is Chair of the MSMA Resident Physician Section and Resident Vice Councilor. MoMed

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Membership Notes

David R. Mehr, MD, assistant professor of family and community medicine at the University of Missouri-Columbia School of Medicine will lead a $2.2 million research project to help physicians and nurses better address a common medical problem in nursing home patients from the U.S. Agency for Health Care Policy and Research. Over the next three years, he and his colleagues will develop a system to identify patients who are most at risk of developing complication from pneumonia and other lower respiratory infections.

George M. Bohigian, MD, volunteered on ORBIS International, Inc., the world's only flying eye hospital, in Yerevan, Armenia October 11-18, 1996. This volunteer nonprofit, humanitarian organization brings eye care as well as teaching to remote parts of the world to fight blindness worldwide. This was the 250th mission and 73rd country that ORBIS has visited.

William Owens, MD, professor of anesthesiology at Washington University School of Medicine and staff anesthesiologist at Barnes Hospital, has been elected president-elect of the American Society of Anesthesiologists.

John T. Anstey, MD, recently received the AMA President's Award of Excellence, for exceptional commitment to the betterment of the health in the St. Louis metropolitan area. The award was presented by AMA President Dr. Daniel H. Johnson, Jr., at the 53rd Carman Lecture in St. Louis.

Dr. Anstey was noted for his leadership as President and Past President of the St. Louis Metropolitan Medical Society, and for the 1994 creation of "Physicians Caring for the Community," a charitable program which continues today.

The AMA President's Award of Excellence was established in an effort to honor individuals, businesses or groups who have made a major contribution to the health of their respective communities.

Frederick W. Hahn, Jr., MD, will receive the Rotary International's "Service Above Self" Award, the highest honor the international service club can bestow on a member.

Dr. Hahn is a 23-year member of the Rotary Club of Independence and is being honored for his charitable work with the Heart to Heart International, Inc. and other civic and charitable projects in the metropolitan area. He was cited for his work in the Heart to Heart airlift of medical supplies to Mother Teresa's medical facility in Calcutta, India, in 1996, and to St. Petersburg, Russia, in 1993. He also arranged for the shipment of a sonography machine to the University of Honduras in 1991. He currently is working to raise funds for printed educational materials for use in the Tibetan refugee camps in northern India. Dr. Hahn is Immediate Past President of the Missouri State Medical Association.

The **Boone County Medical Society** recently announced that **Thomas W. Burns, MD**, has been chosen the 1996 Doctor of the Year. BCMS also elected its 1997 officers. **Michael Perry, MD**, was installed as President; **Milamari Cunningham, MD**, as President Elect, and **Steven B. Standiford, MD**, as Secretary-Treasurer. **Robert Churchill, MD**, will serve on the BCMS Board as an At-Large Member.

The **Cole County Medical Society** installed **Mark Winton, MD**, as President recently. Other members of the Board of Directors are **Randall E. Meyer, MD**, **Robert N. Buffaloe, MD**, and **William R. Kimlinger, MD.** MoMed

In Memoriam

Shael S. Bronson, MD, 75, St. Louis, died November 26, 1996. He was a graduate of Washington University School of Medicine in 1945. He was elected a life-time fellow of the American Psychiatric Association.

William Mowrey, MD, 88, St. Louis, died December 24, 1996. He graduated from St. Louis University School of Medicine. He was on the staffs of DePaul and Christian Northwest hospitals. He retired in 1978.

New Members

MSMA Only

Margaret Anderson, MD
10 Hospital Dr Barnes/Jewish
St. Peters MO 63376
Univ of Mo-Columbia; 1985

Rajsndra Katragadda, MD
9150 E. 41st Terr
Kansas City MO 64133
Guntur Med Col Guntur, India; 1989

Neal Lintecum, MD
6650 Troost Ste 103
Kansas City MO 64131
Univ of Kansas; 1990

William Sistrunk, MD
1900 S. National Ste 2200
Springfield MO 65804
Univ of Mississippi, Jackson; 1990

Daniel Winship, MD
2160 S. First Ave.
Maywood IL 60153
Univ of Texas, Galveston; 1981

Boone

Ahmed Habib, MD
1-E65 CD UHCLS 1 Hospital Dr
Columbia MO 65212
Gandhi Med Coll, India; 1985

Mari A.Z. Keithahn, MD
201 W. Broadway Bldg 5-B
Columbia MO 65203
Duke Univ; 1990

Michael Swanson, DO
1701 E. Broadway Ste 3
Columbia MO 65201
Col Osteop Med & Surg, Des Moines; 1981

John Van Stone, MD
3300 Lemone Blvd
Columbia MO 65201
Northwestern Univ, Chicago; 1966

Buchanan

Phyllis Bogard, MD
910 Edmond St
St. Joseph MO 64501
Univ of Cinannati; 1980

Cape Girardeau

George Pjura, MD
36 Doctors' Park
Cape Girardeau MO 63703
Univ of Conn; 1978

Christine Wester, MD
36 Doctors' Park
Cape Girardeau MO 63703
Univ of Mo-Kansas City; 1991

Matthew Wood, MD
21 Doctors' Park
Cape Girardeau MO 63703
Univ of Mo-Columbia; 1989

Cole

Alan Rauba, MD
200 St. Mary's Med Plz #302
Jefferson City MO 65101
Univ of Mo-Columbia; 1991

Resident-Greene

David Clark, MD
3614 S. Kansas
Springfield MO 65807
Univ of Mo-Columbia; 1996

Jasper-Newton

Alan Morrow Buchele, MD
1513 W. 32nd St.
Joplin MO 64804
Baylor; 1991

Thomas Kartis Jr., MD
1111 McIntosh Circle Ste D
Joplin MO 64804
Univ of NY Stony Brook; 1986

Steven Kory, MD
530 E. 34th
Joplin MO 64804
Univ of Mo-Columbia; 1980

James Riscoe, MD
2727 McClelland Blvd.
Joplin MO 64804
Univ of Mo-Kansas City; 1975

Dana Winegarner, DO
2817 McClelland Ste 114
Joplin, MO 64804
Univ of Okla Osteo Med Tulsa; 1992

Metro Med of Greater KC

Mark Austenfeld, MD
4321 Washington Ste. 5300
Kansas City, MO 64111
Univ of Kansas; 1983

Robert Caffrey, MD
17500 Medical Center Ste #3
Independence, MO 64057
Univ of Mo-Kansas City; 1992

Richard McKittrick, MD
1010 Carondelet Dr Ste 401
Kansas City, MO 64114
Univ of Kansas; 1986

Phillip Munoz, MD
2316 E Meyer Research Med
Kansas City, MO 64132
Univ of Kansas; 1977

Residents-Kansas City

Kimberly Emerson, MD
6601 Rockhill Rd
Kansas City, MO 64131
Univ of Ark; 1996

Daniel Fullmer, MD
6601 Rockhill Rd
Kansas City, MO 64131
Univ of Utah; 1996

Nancy Monaghan-Berry, DO
6512 N.W. Platte Hill Rd
Parkville, MO 64152
Univ of Hlth Sci-Kansas City, MO; 1995

Patrick O'Hara, MD
6601 Rockhill Rd
Kansas City, MO 64131
St Louis Univ; 1996

Kimberly Russell, MD
6601 Rockhill Rd
Kansas City, MO 64131
Univ of Kansas; 1996

David St. Peter, MD
6601 Rockhill Rd
Kansas City, MO 64131

Andrea Sullivan, MD
6601 Rockhill Rd
Kansas City, MO 64131
Univ of Mo-Kansas City; 1996

Christopher Trimble, MD
6601 Rockhill Rd
Kansas City, MO 64131
Univ of Kansas; 1996

Melanie Yuen-McKinney, MD
6601 Rockhill Rd
Kansas City, MO 64131
Univ of Mo-Kansas City; 1996

Northeast

Jon Kiev, MD
711 Grand Ave.
Hannibal, MO 63401
Tulane Univ; 1989

St. Louis Metro

William Baber, MD
1715 Deer Tracks Trail #130
St. Louis, MO 63131
Univ of Ark; 1984

Susan Conger, MD
12161 Manchester Rd.
St. Louis, MO 63131
Univ of Mo-Columbia; 1992

David Cort, MD
226 S. Woods Mill Rd #58W
St. Louis, MO 63017
Univ of Miami; 1980

Richard DiValerio, MD
3009 N. Ballas Rd. #100B
St. Louis, MO 63131
Wash Univ; 1988

Susan Dobmeyer, MD
1034 S. Brentwood Ste 854
St. Louis, MO 63117
Ohio St Univ; 1984

Barbara Ellzey, MD
3015 N Ballas Rd. Dept EM
St. Louis, MO 63131
Southwest Med School, Dallas; 1978

Dale Fletcher, MD
1715 DeerTrack Trail #130
St. Louis, MO 63131
Univ of Pittsburg; 1986

Juan Garcia, MD
10004 Kennerly Rd. Ste 315
St. Louis, MO 63128
Univ of Puerto Rico; 1982

Gregory Gkalakatos, MD
621 S. New Ballas Rd Ste 101
St. Louis, MO 63141
Wash Univ; 1991

John Groll, MD
3009 N. Ballas Rd.
St. Louis, MO 63131
Univ of Illinois; 1988

Walter Holloman, MD
1715 Deer Tracks Trl Ste 130
St. Louis, MO 63131
Univ of Texas, Galveston; 1972

Madhavi Kandula, MD
3009 N. Ballas Rd. #100B
St. Louis, MO 63131
Northeastern Ohio Univ; 1987

Tina King, MD
3009 N. Ballas Rd. #100
St. Louis, MO 63131
Univ of Mo-Kansas City; 1988

Joel Koenig, MD
3009 N. Ballas Rd. #141
St. Louis, MO 63131
Vanderbilt, TN; 1982

Beth Levy, MD
16 Spoede Lane
St. Louis, MO 63141
Univ of Mo-Columbia; 1982

Julie Mack, MD
3015 N Ballas Rd
St. Louis, MO 63131
Harvard; 1990

Amy Mosher, MD
1715 Deer Track Trl Ste 130
St. Louis, MO 63131
Univ of Mo-Columbia; 1984

Jennifer Page, MD
10016 Kennerly Rd.
St. Louis, MO 63128
Univ of Mo-Kansas City; 1992

Joseph Rudolph, MD
1448 Pine Tree Lane
St. Louis, MO 63119
St. Louis Univ; 1982

Randy Silverstein, MD
3009 N. Ballas Rd. #100
St. Louis, MO 63131
Univ of Mo-Columbia; 1982

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William Stetson, MD
10 Barnes West Drive #100
St. Louis, MO 63141
Univ of Southern Calif, Los Angles; 1989

Maureen Stoffa, MD
3009 N Ballas Rd. #100
St. Louis, MO 63131
Jefferson Med Col, Philadelphia; 1993

Deborah Wadsworth, MD
1715 Deer Tracks Trail Ste 130
St. Louis, MO 63131
Univ of N Carolina; 1986

Harry Wadsworth, MD
3009 N. Ballas Rd. Suite 100
St. Louis, MO 63131
Texas Tech Univ Health Science; 1983

Darren Wethers, MD
1034 S. Brentwood Ste 880
St. Louis, MO 63117
Northwestern Univ Chicago; 1988

Michele Woodley, MD
3009 N. Ballas Rd. #100B
St. Louis, MO 63131
SUNY Stony Brook NY; 1986

Resident-St. Louis

Mary Martin, MD
1340-C McCutcheon Rd.
St. Louis, MO 63144
SUNY Downstate, Brooklyn; 1996

Students - UMC

Jeffrey Alten, Matthew Brandt
Nadia Ghafoor, Sara Lander

Students-UMKC

Shahina Hakim, Greg Howell
Steve Lai, Justin Ranes

CME Calendar

The continuing medical education accreditation program of the MSMA has full approval by the AMA's Council on Medical Education. The institutions and functions listed here qualify for Category I credit for the AMA Physician's Recognition Award. All accredited institutions in Missouri are invited to send CME information for free listing in *Missouri Medicine.*

FEBRUARY

10 - *St. Louis*: New Insights into Costs and Motivations for Self Referral. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

15 - *St. Louis*: Diabetes Update. Call 1-800-553-2712.

21 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.

27 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.

28 thru March 2 - *Columbia*: 20th Annual Family Practice Update. Call UMC at 573-882-0366.

28 thru March 2 - *St. Louis*: Advanced Human Neuroanatomy. 19 credit hours. Call 314-525-4000.

MARCH

6 & 7 - *Kansas City*: Hospice and End-Stage Dementia. 9 credit hours. Speakers: Ladislav Volicer, MD, PhD. Call Barbara, Truman Medical Center 816-283-4519.

8 - *St. Louis*: Hepatobiliary Disease. Call 1-800-553-2712.

10 - *St. Louis*: The Role of Nuclear Medicine in Assessment of Infections. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

12 thru 14 - *St. Louis*: The Tenth National Symposium Noninvasive Diagnosis of Vascular Disease. Call 314-569-6290.

14 - *St. Louis*: Bleeding Disorders. Call 1-800-553-2712.

21 - *St. Louis*: Anatomy for Emergency Physicians. 4 credit hours. Call 314-535-4000.

21 & 22 - *St. Louis*: Integrated Care of the Thoracic Surgery Patient. A Seminar for Allied Health Professionals. Call Washington University School of Medicine 314-362-6891.

27 thru 29 - *St. Louis*: Surgical Approaches to the Skull Base. 22 credit hours. Call 314-535-4000.

APRIL

8 thru 10 - *St. Louis*: Microsurgical Techniques for Epilepsy and Intrinsic Brain Tumors. 27 credit hours. Call 314-535-4000.

10 thru 13 - *Kansas City:*
MISSOURI STATE MEDICAL ASSOCIATION ANNUAL CONVENTION.
CME offered by more than 15 medical specialties. Held at the Westin Crown Center.
Call 573-636-5151 or see page 60 in this ***Missouri Medicine*** to preregister!

11 - *St. Louis*: Allergy for the Clinician. Call 1-800-553-2712.

14 - *St. Louis*: Leroy Sante Lecture. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

18 - *Lake Ozark*: Mental Health and Aging. Call 1-800-553-2712.

21 thru 25 - *St. Louis*: Medicolegal Death Investigators. Call 1-800-553-2712.

25 - *Branson*: Update: Primary Care. Call 1-800-553-2712.

MAY

12 - *St. Louis*: Radiologic/Pathologic Correlates in Bronchogenic Carcinoma. Call R. Gilbert Jost, MD, Malinckrodt Institute of Radiology at 314-362-7130.

30 & 31 - *St. Louis*: Neurosurgical Endoscopy. 14 credit hours. Call 314-535-4000.

JUNE

5 thru 8 - *Lake of the Ozarks:* Missouri Academy of Family Physicians 48th Annual Meeting. 18 credit hours.

9 thru 11 - *St. Louis*: Strengthening Instructional Skills. Call 1-800-553-2712.

21 - *St. Louis*: Summer Geriatrics Inst. Call 1-800-553-2712.

JULY

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Journal of the Missouri State Medical Association
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"Barn at Evening" is a 24"x36" acrylic painting by Joe Orr. Mr. Orr is a professional painter from Eldon, Mo.

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"Employed Physicians: A Growing Demographic Trend"

J. Regan Thomas, MD, Editor

The face of medical practice is changing, at least as it is reflected by changes in the number of so-called "employed physicians." The term refers to doctors employed or salaried by a group rather than self-employed physicians who own their practice. This is in contrast to "unemployed physicians" which hopefully is not an issue in the near future.

A recent article in the St. Louis Medical Business Journal indicated that employed physician numbers are growing at an increasing pace, and as of 1995, represent 39% of the practicing physicians. This figure is up from 36% a year earlier and is expected to continue to increase. There are a few doctors, about 6%, who consider themselves private contractors or temporary workers. Physicians who own their practice have dwindled from 58% to 55% over that time span according to the article.

Why is this demographic changing? On the surface it does not appear to be an obvious economic decision. American Medical Association figures demonstrate median incomes of employed physicians are less than those who are self-employed. In fact, since 1995 self-employed physicians median income actually rose at a greater rate than employed physicians (a 13.1% increase versus a 4.6% increase). So what is the reason more doctors are becoming salaried employees rather than traditional solo or small group self-employed physicians in the face of less income on the average? Perhaps the answer is more doctors feel they have no choice. Particularly in mature managed care markets, they may feel their ability to compete alone is less likely. They are willing to accept a lesser income in order to have less concern about competing in a difficult and evolving medical practice environment.

Employed physicians are willing to accept a lesser income in order to have less concern about competing in a difficult and evolving medical practice environment.

Maybe part of the answer is societal or attitudinal in nature. Is there a medical cultural change that makes becoming an employed physician more desirable or less uncomfortable than the self image of past physician generations? AMA figures again report self-employed physicians as a group are more experienced, chronologically older, and are working more hours. The hours worked, in fact, may be an insight to a social phenomenon. Frequently, residents in training point to lifestyle or quality of life as more important to them in developing their careers than income. Regular hours, call coverage, weekends, and a dependable, secure income (even if it is somewhat less) may be goals more readily achieved through a contractual employment arrangement rather than self-employed, traditional private practice. Possibly, younger physicians simply accept the present trends as the norm and thus, are less troubled or resistant to it.

As a medical student, I took advantage of the opportunity to spend time in London to do a medical school clerkship. As I discussed the differences in our systems and the contrasts with the British system as it existed then, I quickly realized an important fact. None of the English counterparts considered any alternatives or had any memory or experience with a system that was different. It was for them, simply the norm. A similarly difference of generational insight may now be part of the explanation for active change in physician employment demographic data.

Whatever the cause, the face of medicine is indeed changing. Those changes have important implications for organized medicine at both AMA and MSMA levels. Specialty organizations must also be sensitive to the needs and goals of employed physicians. It is difficult to predict with any precision the changes to come in the next few years. One prediction is safe, it will be different than the present status quo. **MoMed**

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New Managing Editor Joins MSMA Staff

Michelle Poire recently joined the MSMA staff as Managing Editor of *Missouri Medicine*.

"I look forward to producing a quality Journal in a timely manner," Poire said. "I am open to any suggestions MSMA members have to make this an even better Journal."

Poire received her BS degree from Truman State University, Kirksville, Mo. She comes to MSMA after seven years in the Marketing/Public Relations Department at Capital Region Medical Center in Jefferson City.

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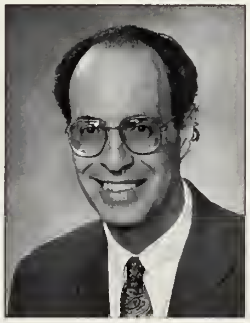
MSMA General Session

April 11, 9:00-10:30 a.m.

Steve Wetzell is the executive director of the Buyers Health Care Action Group, a coalition of 24 Twin City-based employers providing health care for 400,000 employees, retirees, and dependents throughout Minnesota, western Wisconsin and eastern North and South Dakota.

MSMA General Session

April 11, 2:30-4:00 p.m.

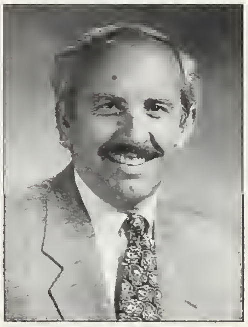


Edward Hirshfeld is Vice President and Associate General Counsel for Health Law of the American Medical Association (AMA). He directs the Health Law Division of the AMA, which is responsible for medico-legal policy initiatives, counseling the Association about health law issues, and coordinating the AMA's initiatives in the managed care area.

Robert F. Leibenluft is Assistant Director for Health Care of the Federal Trade Commission's Bureau of Competition. Mr. Leibenluft writes and lectures extensively on health law topics. His articles on health care have appeared in *The New England Journal of Medicine, Vanderbilt Law Review, The American Journal of Psychiatry, Business and Health, Pharmaceutical Executive, Medical Devise & Diagnostic Industry, The BBI Newsletter*, and other books and journals.

Organized Medical Staff Section General Session

April 12, 10:00 a.m. - 12:00 noon



Joseph Green, PhD, served as Director of Continuing Medical Education and Vice President of Medical Education for Sharp HealthCare, an integrated health care system in San Diego, Ca., since 1989. He is also president of Professional Resource Network, Inc., a consulting firm which has provided assistance to several national specialty societies, medical schools, voluntary associations, and hospitals.

Robert Pyatt, MD, is the acting Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians. He has been serving for the past four years as an ACCME national surveyor. Dr. Pyatt has been selected to serve on the Board of Examiners with the 1996 Malcolm Baldridge National Quality Award; only a few physicians in the United States are selected for this honor, and he is the first member of the CME community who has achieved this status.

Missouri State Medical Services General Session

April 12, 2:00 p.m.-4:00 p.m.

W.L. Douglas Townsend, Jr., is a managing director and the CEO of Townsend Frew and Co., L.L.C., a specialty investment bank in Durham, N.C., which assists physician groups in implementing their strategic plans through raising debt capital or negotiating on the group's behalf in the selection of a strategic equity partner.

"The Good Old Days"

Daniel O'Sullivan, MD, MSMA President

After a year of traveling throughout the state and country as your MSMA President, a multitude of problems have been identified as the primary challenges of medicine for the future. Most of these are either professional or socioeconomic and have been the objects of discussion and debate in this expanded and modified version of *Missouri Medicine*. Through our excellent editor, J. Regan Thomas, MD, and our Executive Vice President, Cork Swarens, our state magazine has taken a new look, a stronger voice, and serves as a primer for the physicians of our state as they face the challenges of our times. In the future, these will be referred to as the "Good Old Days."

Membership is the word we all must recognize as the dominant need of MSMA. Membership means quality as well as quantity. Most of our efforts have been expended at increasing the numbers in our Association. As most already know, we only represent half of the 12,000 physicians in Missouri, but we serve all. The coffee clutch cry of physicians is "What does the medical society do for me?" Your officers, and hopefully your members, spend hours trying to answer this question which I see as a lazy, cowardly cover-up. The answer is already available.

As is true of most doctors, I have been involved in membership drives at all levels and fund raising efforts of varied types. One principle abides in all circumstances and that is a good product. That means a fine school, a well-equipped athletic club, a caring children's home or program, and a strong, able, available, and affable medical society. Each year new services are added to benefit our members.

Several areas of activity are apparent. The most notable and important ongoing efforts of MSMA are exerted in the legislative area creating, affecting, supporting, opposing state and national lawmaking committees. Tom Holloway and Cork Swarens spend 90% of their efforts in this area. Education of doctors in Missouri, members or not, is approved and reviewed by our CME Committee for nearly all hospital programs throughout the state. Ron Ellison is in charge of this time-consuming program. Ron and Jeff Howell have recently set up an Internet access and web page to bring communication into the 21st century. Lizabeth Starnes puts together *Progress Notes*, a bulletin of activity, for those who prefer telegrams to hypertext.

Much of my efforts in the last three years have been related to Missouri State Medical Services, Inc. (MSMS), a corporation formed to meet the challenges of managed care in the 90s. We are currently completing contractual negotiations to form a statewide MSO to support IPAs throughout the state. This will be an excellent service to our members. Pat Mills has been a leader in MSMS and his services have been constant and loyal.

Jeff Howell has energetically raced to county and local societies promoting membership and extolling these benefits I outlined above. We don't understand why every doctor doesn't join, since everyone benefits from our activity. As Charles Norland, SLMMS President, recently said in a *Missouri Medicine* article, "Let everyone pay the fare for the bus ride."

As we experience daily the scientific advances of medicine which surround us, many of us in the silver-haired generation look back 20 years or so and ask, "Were those old days so good?" Imaging systems never dreamt of, advances in oncology, orthopedic, cardiac and cataract surgery, and every other field of medicine, bring home the reality: for the patient, these will be the "Good Old Days."

Our state medical schools are deluged with applications -- 7,000 applicants to the University of Missouri-Columbia and St. Louis University Schools of Medicine sought about 100 positions in each school. A few students could get in anywhere and others nowhere. The majority of these applicants are nearly identical: good GPA, adequate MCAT, and a friend or relative who is a doctor. These young people perceive medicine as an honorable profession worthy of the effort and sacrifice it demands. They know the good old days are now.

Every member of MSMA needs to convince one non-member to join, pay hisor her share, and actively participate in the effort to strengthen our voice and make things better for the patients and physicians of our state. MoMed

Board of Healing Arts Investigative Process

Nicholas F. Robinson, MD,
President, Missouri State Board
of Registration for the Healing Arts

Nicholas F. Robinson, MD

The Missouri State Board of Registration for the Healing Arts reviews approximately 700 complaints and 800 malpractice claims each year. Pursuant to Missouri statutes and rules, the Board is obligated to investigate each one. Complaints come from several sources including the public, fellow physicians, administrators, etc. Reports of malpractice claims come from the Missouri Department of Insurance as required by law. Also, adverse actions regarding staff privileges in hospitals or ambulatory care facilities are required by statute to be referred to the Board.

An investigation often begins by requesting the physician respond in writing to the complaint that has been filed with the Board. The response is then forwarded to the Disciplinary Chairman for review, who in turn makes a recommendation to the Board at the next meeting. This recommendation may be to close the investigation or to consider further investigation or action.

If the complaint regards quality of care, the investigation generally begins with a request for patient records. This request is sent in the form of a signed authorization for release of records or a Board subpoena. These records are reviewed by one or more of the Board's medical staff investigators who are licensed physicians. The case is then assigned to one of the fifteen investigators employed by the Board. The investigator typically interviews the complainant, the physician, and any other relevant parties. Whenever possible, this is done by appointment with the physician. A copy of the complaint is generally given to the physician before the interview unless the Board feels the complaint is of a criminal nature or that providing a copy of the complaint could result in harm to the complainant or could hinder the Board's investigation. These situations involve a very small percentage of the cases. The physician is welcome to have an attorney present during the interview. The investigator then proceeds with any additional investigation and presents a written report to the Board.

Upon review of all available information, the Board may take any of the following actions.

- Close the case with no action;
- Issue a letter of concern (not disciplinary action and not reported to the physician data bank, but kept on file in the Board office as a closed record);
- Refer the information to the Attorney General's office to file a complaint with the Administrative Hearing Commission, or to enter into a settlement agreement with the physician;
- Subpoena the physician to meet with the Board's medical staff regarding the alleged violation for the purpose of obtaining additional information. The physician's legal counsel is welcome to attend this medical staff interview with the physician. The medical staff then reports its findings back to the Board;
- Any and all other action as authorized by law.

The Board's investigation is considered confidential until final disciplinary action is taken or until a complaint is filed with the Administrative Hearing Commission. If the investigation is closed with no action or closed with a Letter of Concern, the matter remains confidential unless the licensee executes a signed authorization to release the information to specific parties.

Because of implementation of a new policy regarding timely review, new procedures and additional time devoted by Board members, the majority of cases are resolved within 12 to 18 months. Cases referred to the Attorney General for disciplinary action may take longer, but the physician is notified of the status of the case.

If you have any questions regarding the Board or would like a copy of the Board's new policy regarding timely review, please call 573-751-0098. MoMed

Strategic Options for Physician Groups

W.L. Douglas Townsend, Jr.

The author will present his views on physician organizations on Saturday, April 12, during the 1997 MSMA Annual Convention at the Westin Crown Center in Kansas City.

In "Physician Organizations: Historical Fact vs. Current Reality," which appeared in the February issue of *Missouri Medicine*, the transformation of the health care environment and how it has changed the way physicians are required to run their practices was discussed. The bottom line is physicians must organize into more classic business models in order to implement strategies that will help them profitably operate in a capitated managed care environment. This requires capital investment in a number of different areas, including physician networks, information systems and management expertise. Physician groups can choose from several strategic options in their pursuit of organization, which include expanding independently, consolidating with other clinics or selling to a strategic partner.

1 *Expand Independently*

Clinics that are good candidates for this strategy exhibit the following characteristics:

- Strong clinic leadership;
- Sound, well-developed business plan endorsed by physicians;
- Ability to make decisions quickly;
- Average age of clinic's physicians is less than 45;
- Physicians have a strong desire to maintain autonomy;
- Access to internally or externally generated capital;
- A focus on "organizational wealth," versus "personal wealth."

If physicians pursue this option, the potential sources of organizational capital include retaining earnings, obtaining standard commercial bank financing, raising venture or strategic capital or developing an MSO partnership. Retaining earnings requires clinics to hold back a portion of previously distributed physician income in order to reinvest it in the clinic. Bank financing involves securing a loan, which often requires assignment of hard assets as collateral and personal guarantees as additional security. There are also venture capital firms that will invest in physician organizations, but the organizing group must be able to demonstrate returns on capital in excess of 35% and a planned return of capital (commonly known as an "exit strategy") within five to seven years. Strategic capital, we often find, has lower return expectations and less sensitivity to near term repayment. In an MSO partnership, two or more clinics form a management organization that provides administrative services to their clinics, allowing them to spread over a larger base the fixed cost of information systems and other capital expenditures. Many groups also seek to contract/outsource their office management to third parties. There are several advantages in following this strategy as well as several considerations for physicians to make before reaching a decision. (See Table 1)

2 *Multi-Clinic Consolidation:*

This strategy is a good fit for clinics with the following characteristics, many of which are similar to those in Section 2:

- Strong clinic leadership;
- Desire to maintain autonomy;
- Access to internally or externally generated capital;
- A focus on "organizational wealth," versus "personal wealth;"
- Value of combined organizations is greater than the sum of the individual groups.

This option can take several different directions. Clinics pursuing this strategy may choose to merge with a similar clinic in their own market. If several large clinics are willing to merge and can demonstrate potential for future growth, they could eventually file for an initial public offering and form a publicly traded company. The strategy allows the clinic not only to access capital, but also to quickly gain critical mass. The advantages and considerations for this strategy are listed in Table 1.

3 *Sell to Strategic Partner*

Candidates that fit this strategy have the following characteristics:

- Management resources and infrastructure are not sufficient to take capitation profitably;
- Average age of physicians is greater than 45;
- Physician shareholders are looking for liquidity;
- Physician panel too small or specialist-dominated to attract HMO contracts;
- Insufficient access to capital needed to position for managed care.

Strategic partners can include physician practice management companies (PPMs), hospitals, and HMOs. These organizations are generally larger than physician groups and often are able to bring needed capital and management expertise. However, the large majority of physician groups that pursue this option end up sharing or giving up total control of clinic operations by virtue of the financial transaction that accompanies these affiliations. The advantages and considerations associated with this strategy are also listed in Table 1.

Continued on page 108

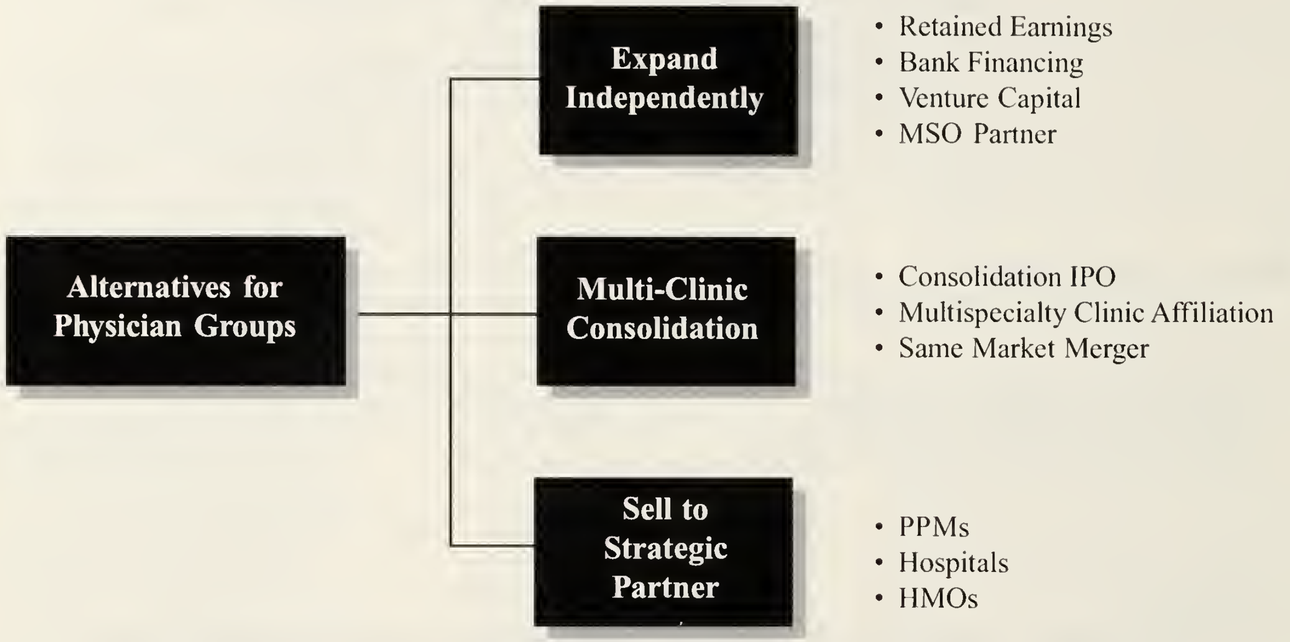
Table 1

Evaluating Strategic Options: Advantages and Considerations

Advantages	Considerations
Expand Independently	
• Maintains ownership control • Ensures operational autonomy and management consistency • Maximum strategic flexibility in the future	• Requires significant capital investment in management, infrastructure, and reserves • Financing capacity would come from commercial lenders, strategic partners, venture capitalists and/or internally generated funds, which may reduce physician compensation or dilute governance and ownership
Multi-Clinic Consolidation	
• Provides critical mass and geographical diversification • Negotiating clout with insurance and managed care companies and other payors on a state-wide and regional basis • Improves access to capital and long-term equity value	• Combining multiple physician groups creates numerous integration challenges in the areas of governance, management, physician compensation, and operational conformity • Relative valuations of participating physician clinics would need to be established
Sale to Strategic Partner	
• Enhances long-term competitive position of clinic as part of a larger, more diverse organization • Clinic shareholders monetize equity value in clinic • Gain access to Buyer's infrastructure, capital, systems, and management resources	• Relinquishes control of clinic • Uncertain continuity of strategic plan implementation • Preparedness of Buyer's administrative infrastructure to integrate clinic and create economies of scale • Managed care and clinical management of Buyer ("Value Addeds")

Continued from page 107

Overview of Strategic Alternatives for Physician Groups


Alternatives for Physician Groups
Expand Independently
• Retained Earnings
• Bank Financing
• Venture Capital
• MSO Partner
Multi-Clinic Consolidation
• Consolidation IPO
• Multispecialty Clinic Affiliation
• Same Market Merger
Sell to Strategic Partner
• PPMs
• Hospitals
• HMOs

Conclusion

The strategic decision of how best to source management expertise and capital resources is a decision that will usually be made only once, and it can impact all aspects of a clinic's operations. Physicians may have to give up part or all of the ownership of the clinic and/or take a cut in salary. Therefore, the decision-making process requires a careful evaluation of the clinic's current position as well as its goals. There is no "right" way to proceed, but making an appropriate match between the clinic and the source of capital and management expertise is the best way to ensure the clinic and its physicians will continue to grow and prosper in the years to come. MoMed

The Author

W. L. Douglas Townsend, Jr., is a managing director and the CEO of Townsend Frew & Co., L.L.C., a specialty investment bank located in Durham, North Carolina, which assists physician groups in implementing their strategic plans through raising debt capital or negotiating on the group's behalf in the selection of a strategic equity partner. Prior to establishing Townsend Frew & Co., Mr. Townsend served four years as Executive Vice President of Corporate Development for Coastal Physicians Group.

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Reengineering: Your Guaranteed Solution to Reducing Costs and Increasing Efficiencies

Diane L. Arnold, CPA, Manager/Health Care Consultant

Although sometimes overused, the term "Reengineering" is the most appropriate term and the key to long-term success for physicians in today's health care market. Managed care and a marketplace that is reforming itself have created a volatile environment for physicians. As revenues decrease and costs increase, physicians are finding themselves faced with a continual barrage of issues and questions ranging from "In which managed care plans should we participate?" to "Should we outsource certain office activities to reduce costs and increase profit?"

These questions can be difficult to analyze and even more difficult to actually answer. However, *those physicians who are able to answer these questions are the ones who will succeed in today's health care arena.* Physicians must begin *now* to take a hard look at office procedures, costs, and how to change to become more efficient. At the same time, physicians must improve or at least maintain the quality of care provided.

The process of reengineering usually begins with a study that accounts for time, activities, and costs in the medical practice. A time and motion study is utilized to examine how a practice uses staff, time, equipment, and other resources. By tracking the time and activities of those people providing health care, a model is developed of your physician practice. In effect, each patient seen during the study is tracked through the processes involved in providing health care in your medical practice. It is this model that also allows you to ask a series of "what if" questions -- what if we: add another physician, close our satellite location, sign this capitated contract? A time and motion study allows the practice to make informed decisions based on known outcomes. By combining full absorption cost accounting with the time and motion study, the medical practice is also able to determine its costs by CPT code, by physician, by managed care plan, and by location. It is this information that enables physicians to make the changes necessary to become more efficient. Processes within the practice can be altered to reduce costs and increase productivity, and, as such, increase revenues.

To determine whether your medical practice is a candidate for reengineering, answer the following critical practice management questions:

- Which are our most profitable CPTs?
- How can unprofitable CPTs be made profitable without lowering the quality of care?
- Which HMO and PPO plans net the most profit for our practice?
- What is the optimum health plan mix for our practice?
- Are we making money on our capitated contract?
- What are the anticipated financial results of signing a given managed care contract?
- Do we have frequent cost overruns?
- Should we outsource certain office activities to reduce costs and increase profit?
- Do we know the costs to deliver a particular service, or if that service is even profitable?
- Why is Doctor "A" more efficient than Doctor "B"?

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- Are we efficiently utilizing our staff resources?
- Should we add a physician? A new procedure?

Can you answer these questions? If not, you are a definite candidate for reengineering. If you can, how accurate are your answers? Are they based on estimates and assumptions? Or even worse, are they based on fears and emotions? If they are, you are also a definite candidate for reengineering.

Everyone agrees in order to ensure the long-term viability of your practices, you must reduce your costs. You must know what your costs are and what drives those costs in order to reduce them. The market has been flooded with information on methods to determine what the costs are of providing health care in your practice. A time and motion study goes beyond several methods currently in use.

One popular method of determining costs is to divide your practice's total overhead by the total number of RVUs performed during the period the costs were incurred. This approach requires one basic assumption -- the relative values you use properly reflect the distribution of your costs to your procedures.

By analyzing how you do things now and what the cost and outcome of that is, you can begin to change to improve the outcome and decrease the cost.

Unfortunately, this assumption also represents this method's major weakness. It assumes that all physicians, regardless of their market, practice styles, size and specialty utilize their resources the same. This is not true, because no two practices, or two physicians for that matter, utilize their resources in the same manner. In effect, it is an arbitrary assignment of costs to procedures.

Studies have shown that these cost estimates may be incorrect by as much as 600%. This is not the type of information that should be relied on to make critical decisions for your practice, and unfortunately most of the methods currently on the market have similar weaknesses. And you still haven't even begun to analyze where inefficiencies might exist in your practice.

How are you going to address the issue of inefficiency in your practice? At best, it is difficult or impossible to determine where inefficiencies might exist. Assuming you have the time and resources, again you have to ask yourself how accurate the information is you're utilizing. A time and motion study is the most accurate method of analyzing inefficiencies. The development of a model of each practice studied, allows for the analysis of the processes involved in the delivery of health care in each individual practice. By analyzing these processes, physicians can actually see where bottlenecks, duplications of effort and other inefficiencies are within the practice.

A time and motion study will enable physicians to answer the questions posed above and numerous others. Unfortunately, this is not enough. *Physicians must be willing to make changes within their practices and in their own individual practice styles in order to succeed.* Your associate may be providing much higher quality health care in a more efficient manner. Wouldn't you like to know that and be able to learn and benefit from him or her? A soon to be unveiled technology will allow physicians to track their outcomes and establish protocols based on those outcomes and the related costs. By analyzing how you do things now and what the cost and outcome of that is, you can begin to change to improve the outcome and decrease the cost.

A time and motion study can produce dramatic results. One ob-gyn group practicing in the South was just sure they needed to hire a new physician. They all felt overworked and barely able to see all of their patients. After having a time and motion study performed, they were able to identify inefficiencies in the way they were treating patients. The implementation of a few changes enabled each physician to have an extra afternoon off each week. They were able to see more patients each day and they did it without hiring a new physician. They are working smarter now, not harder.

An ophthalmology practice that had a time and motion study performed was provided with invaluable cost information that they were able to utilize in negotiating managed care contracts. They started with their top five CPT codes and analyzed the different practice styles of each physician in the group with relation to each code. They chose to start with only five CPT codes so the changes wouldn't seem so overwhelming. They looked at each cost that went into each CPT and were able to identify both efficiencies and inefficiencies in the processes involved. This enabled them to capitalize upon the efficiencies and eliminate the waste; as a result, these codes are all now much more profitable. Next they want to target their top five losing CPT codes.

Reengineered physicians are working smarter now, not harder.

The most important thing is that they have the information available to make the changes they need to make in order to reduce costs and increase revenues, and they are using that information and making the necessary changes.

The underlying goal of most managed care plans is to reduce costs. That has translated into reduced revenues and increased costs for most physicians. Going a step further, managed care plans are attempting to decrease costs by controlling when care is or is not covered through the use of treatment protocols and precertification requirements. At the same time, capitation reimbursement methods are shifting the risk of caring for a group of insureds to the providers that are contracted to care for those patients.

As a result, you are losing control over how you treat patients. Not only is it scary to have an insurance plan telling you how to treat your patients, but there is no impact on overall health care costs in our country. Physician compensation has steadily decreased over the last several years, while overall health care costs have steadily increased at an alarming rate.

The single most important issue facing you as you try to survive and prosper is how to take back control of the delivery of health care. The answer is to provide the highest quality care at the lowest cost. In order to do that, you will have to make changes within your medical practices. These changes may involve altering the way you treat patients. Many physicians may consider this unthinkable, but the bottom line is that *physicians must be willing to make changes in order to survive and succeed. Success will follow those who are willing to change.* **MoMed**

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Metformin: A Safe and Effective Treatment in the Management of NIDDM

Charles Kilo, MD, FACP
Professor of Medicine, Washington University School of Medicine
Kilo Diabetes Research Foundation

Dr. Kilo is a principal investigator in the metformin monotherapy, combination therapy and dose response studies.

Abstract

The oral antihyperglycemic drug metformin has a unique mechanism of action and controls glycemia in both obese and normal-weight NIDDM patients without inducing hypoglycemia, insulin stimulation or hyperinsulinemia. Metformin used in combination with sulfonylureas has a synergistic effect in lowering fasting and postprandial glucose and hemoglobin A_{1c} levels, and improving the lipid profile. Metformin does not increase lactate production from skeletal muscle and has little clinically significant effect on vitamin B_{12} and folic acid absorption.

Lactic acidosis associated with metformin use is extremely rare (reported incidence of 0.03/1,000 patient-years exposure) and has occurred predominantly in patients for whom the drug was contraindicated. Observance of prescribing guidelines will greatly minimize risk, since risk factors have been identified.

Metformin can be safely used in the elderly, provided prescribing precautions are followed.

Dosing in the elderly should be conservative, with dose adjustment designed to achieve normal blood sugar levels.

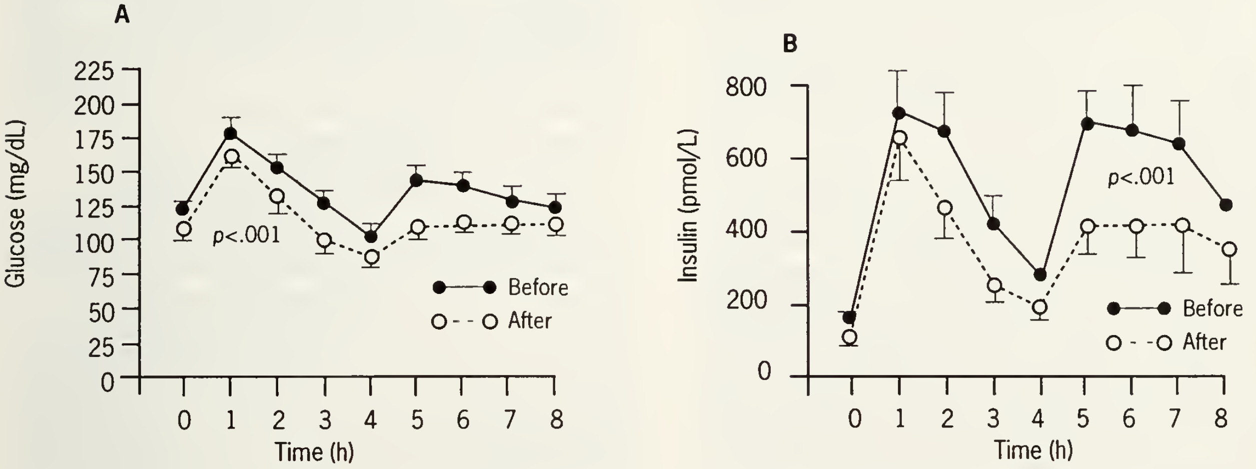
Keywords: metformin, antihyperglycemic, cardiovascular risk, lactic acidosis, non-insulin-dependent diabetes mellitus.

Diabetes mellitus is a major health problem in the United States. Approximately 5-6% of the population has diabetes (American Diabetes Association 1994) and of these, the majority (>90%) has non-insulin-dependent diabetes mellitus (NIDDM).[1]

Diabetes exacts high rates of morbidity and mortality. The direct and indirect cost of diabetes in 1994 exceeded $106 billion. The hyperglycemia of diabetes produces the classic symptoms of polyuria, polydipsia, polyphagia, and fatigue. In the long term, elevated glucose levels lead to tissue damage, including retinopathy, nephropathy, neuropathy, and cardiovascular and peripheral vascular disease.[2-6] Retinopathy occurs in about 60% of patients with NIDDM and is a leading cause of blindness worldwide.[4,7] Diabetic nephropathy accounts for >4,000 cases/year of end-stage renal disease in the United States.[4,7] Diabetic neuropathy and peripheral vascular disease contribute to a 2- to 4-fold higher rate of lower limb amputation among diabetic patients than in the non-diabetic population.[4,5] Peripheral vascular disease occurs four times more frequently among diabetic individuals than among nondiabetic individuals.[5] Diabetic individuals are also at increased risk for cardiovascular and cerebrovascular disease; patients with NIDDM face a 2- to 4-fold higher risk of mortality from these diseases than do non-diabetic individuals.[8]

In order to alleviate and prevent diabetic symptoms as well as prevent long-term complications, tight glycemic control is critical. The importance of tight control was proven conclusively by the recent Diabetes Control and Complications Trial[9] and the Stockholm Diabetes Intervention Study.[10] In these studies, maintenance of normal or near-normal glycemia not only

Figure 1. (A) Plasma glucose and (B) plasma insulin levels before and after metformin monotherapy. Reprinted from Hollenbeck and associates[47] with permission.

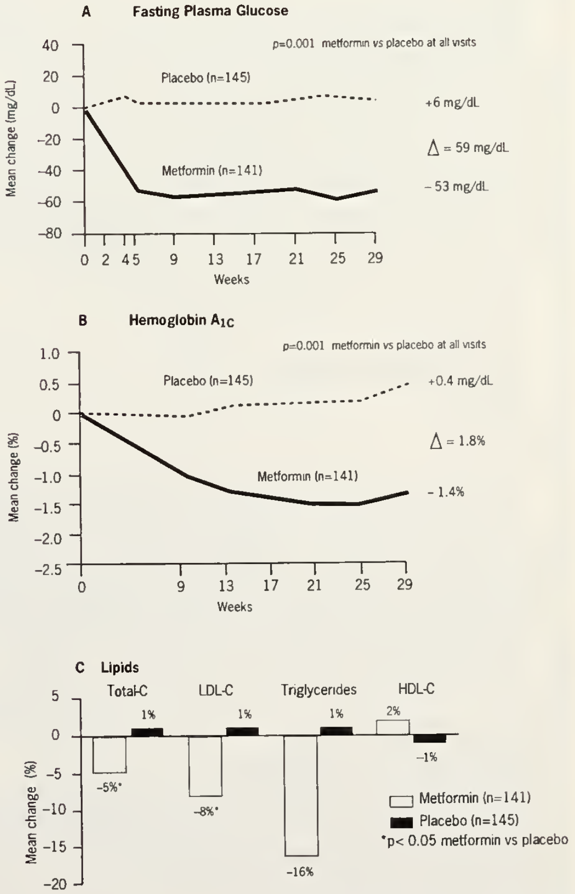


relieved diabetic symptoms but also significantly delayed the onset and progression of diabetic retinopathy, neuropathy, and nephropathy in patients with insulin-dependent diabetes mellitus.[9] These important findings resolve the long-standing controversy that resulted when the earlier University Group Diabetes Program study[11] concluded that controlling blood glucose levels was of no benefit in preventing microvascular and macrovascular complications.[4,12,13] The conclusions of the UGDP were refuted by Kilo, Williamson, and associates.[2,3,12-17] Based on the knowledge that microvascular complications are related to the severity and duration of hyperglycemia,[4,7,13,17-19] it is presumed that tight glycemic control in individuals with NIDDM would provide the same long-term benefits as those in evidence in the Diabetes Control and Complications Trial and the Stockholm Diabetes Intervention Study.

Metformin is an oral antihyperglycemic drug that was introduced in Europe in the late 1950s and has been widely prescribed for the treatment of NIDDM in most countries. It has recently been made available in the United States. Metformin accounts for 25% of prescriptions for oral glucose-lowering drugs in the United Kingdom[20] and is the only biguanide recommended by the European NIDDM Policy Group for the treatment of NIDDM. Metformin has also been a treatment option for patients in Canada since 1972, where its safety has been supported by clinical experience for approximately 56,000 patient-years.[21]

Unlike sulfonylureas, metformin reduces hyperglycemia and hemoglobin A_{1c} levels without stimulating insulin secretion, causing hypoglycemia, or promoting weight gain (see Figures 1 and 2). It also has

Figure 2. Mean change from baseline in (A) fasting plasma glucose, (B) hemoglobin A_{1c} and (C) lipids (where C = cholesterol) for metformin monotherapy compared with placebo[37].



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a favorable effect on lipid homeostasis. Metformin is often the preferred treatment for overweight patients with NIDDM in the United Kingdom.[20,22] However, metformin is also effective in patients who are of normal weight or are mildly overweight, and is a logical first-line choice for patients who are prone to hypoglycemia or have elevated lipid or insulin levels.[20,23-29]

Metformin has been shown to be effective in achieving glycemic control when administered alone or in combination with other oral antihyperglycemic agents. As monotherapy, it is as effective as first-generation (e.g., chlorpropamide and tolbutamide) and second-generation (e.g., glipizide, glyburide) sulfonylureas[23,30-33] in patients with NIDDM. In most comparative studies, the main difference between the two treatments was that patients receiving metformin usually lost weight whereas patients receiving sulfonylureas gained weight. Most patients with NIDDM refractory to sulfonylurea therapy plus dietary control achieve good glycemic control without significant increases in plasma insulin levels or weight gain when metformin is added to their current NIDDM therapy.[25]

Favorable effects on other metabolic parameters have been demonstrated with metformin therapy. Metformin reduces hypertriglyceridemia and improves insulin sensitivity.[34,35] Significant reductions in total and low-density lipoprotein levels in diabetic patients have been demonstrated[25] and have been shown to persist for five or more years with metformin therapy.[36] An increase in high-density lipoprotein cholesterol and a reduction in blood pressure have also been observed.[27]

METFORMIN IN CLINICAL USE

Efficacy

The antihyperglycemic effect of biguanides has been documented in numerous therapeutic trials. Biguanides lower blood glucose in patients with NIDDM by various mechanisms, including the reduction of hepatic glucose production, the enhancement of insulin-stimulated glucose utilization in peripheral tissues, fat, intestinal tissues, and probably erythrocytes, the enhancement of insulin-stimulated glycogen synthesis, and the reduction of intestinal glucose absorption.

The efficacy of metformin in controlling hyperglycemia in patients unresponsive to diet alone has been demonstrated in several studies (see Figure 2).[37] Metformin monotherapy and combination therapy with glyburide produced reductions in mean baseline fasting plasma glucose, two-hour postprandial plasma glucose, and HbA_{1c}.[25,26,31,38,39] Furthermore, decreases in fasting plasma glucose and HbA_{1c} with metformin plus glyburide were greater than those seen with either drug alone, suggesting a synergistic effect[25] (see Figure 3). The decrease in plasma glucose is associated with decreased plasma insulin levels.

Fasting plasma glucose and HbA_{1c} were both significantly reduced compared with diet alone in the United Kingdom Prospective Diabetes Study,[33] which assessed 2,520 patients with NIDDM over three years duration. Normal-weight patients received dietary therapy alone or in combination with chlorpropamide, glyburide, or insulin and overweight patients received dietary therapy alone or in combination with metformin, chlorpropamide, glyburide or insulin. Chlorpropamide, glyburide,and insulin recipients had a significant weight gain compared with patients treated by diet alone ($p < 0.001$). Furthermore, the weight change among obese patients receiving metformin therapy was no different from the weight change among obese patients who received dietary therapy alone. The authors concluded there was no difference in efficacy in reducing glycemia among patients receiving chlorpropamide, glyburide, insulin or metformin.

Glycemic control with metformin has been demonstrated to be equivalent to that observed with glyburide,[31,40-42] tolbutamide,[32] and chlorpropamide,[30] and superior to that observed with glipizide.[43] Only metformin demonstrated beneficial effects in body weight and serum lipid profiles in these studies.

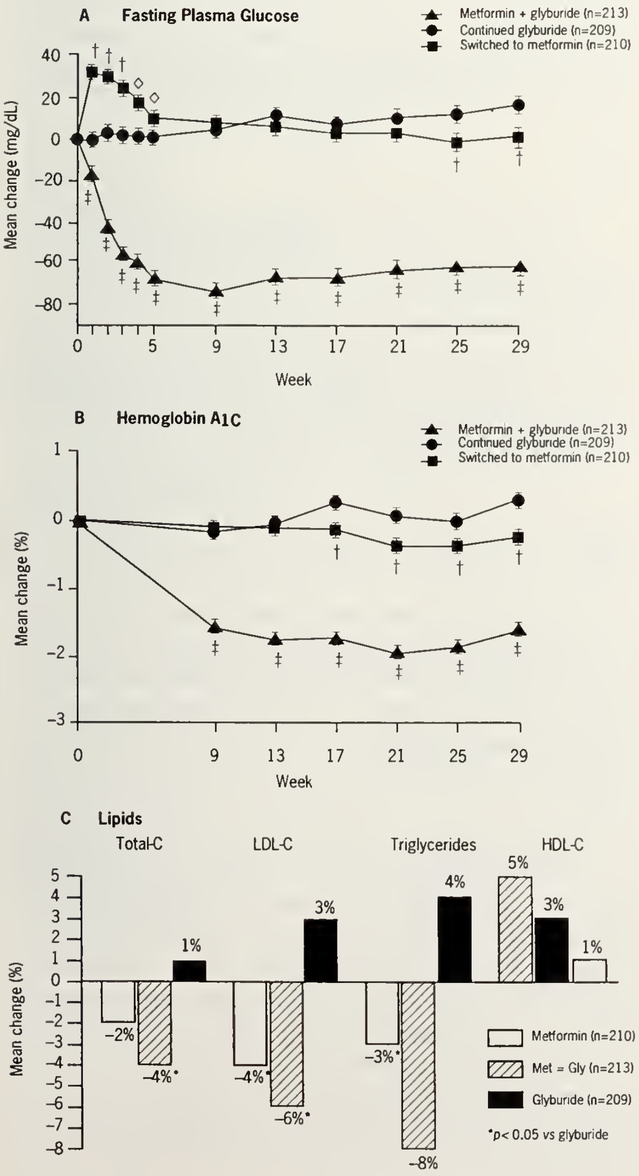
Metformin has been shown to ameliorate insulin resistance by improving insulin action via a multifactorial mechanism mediated by membrane-binding properties. It may also have an insulin-independent effect on glucose utilization.[44,45] Improvements in lipoprotein metabolism have been documented in several studies. In one study, fasting plasma insulin, fasting plasma glucose, and postprandial plasma glucose concentrations were reduced after three months of metformin therapy in patients with NIDDM. The improvements in plasma glucose response 8 to 16 hours after metformin administration was associated with a small but significant reduction in circulating plasma insulin concentration.[46]

The efficacy of metformin in elderly NIDDM patients was similar to that for tolbutamide, and the clearance of metformin in these patients was adequate.[32] Blood lactate levels of patients receiving from 500 to 3,000 mg/day of metformin did not change significantly from baseline. It should be noted that metformin is

Figure 3. Effect on (A) fasting plasma glucose, (B) hemoglobin A$_{1c}$ and (C) lipids of metformin monotherapy, sulfonylurea monotherapy, and metformin + sulfonylurea combination therapy. † $p < 0.001$ metformin vs glyburide; $p < 0.01$ metformin vs glyburide; ‡ $p < 0.001$ combination therapy vs glyburide. Reprinted from DeFronzo and associates[25] with permission.

(A) Mean changes in fasting plasma glucose from baseline at week 29:
Metformin + glyburide = -64 mg/dL
Continued glyburide = +14 mg/dL
Switched to Metformin = -1 mg/dL
Overall change = 78 mg/dl

(B) Mean changes in Hemoglobin A$_{1C}$ from baseline at week 28:
Metformin + glyburide = -1.7%
Continued glyburide = +0.2%
Switched to Metformin = -0.4%
Overall change = 1.9%



contraindicated in patients with renal dysfunction, and the potential for reduced renal function in elderly patients highlights the need for conservative initial dosages in this patient population.

NIDDM is associated with a substantially increased risk of cardiovascular disease: 80% of NIDDM patients die of atherosclerotic disease. Abnormal levels of serum lipids are known risk factors for cardiovascular disease, and therapy with metformin has demonstrated favorable effects on serum lipids that are often abnormal in NIDDM patients. Metformin monotherapy and combination therapy with a sulfonylurea induces modest reductions in plasma concentrations of triglycerides and total-cholesterol and LDL-cholesterol concentrations.[20,25,27,39,47,48] Modest elevations of plasma HDL-cholesterol levels have also been observed.[25,27,28,46,47,49] The mechanism of these lipid changes is unclear; they may occur via a direct effect of metformin on VLDL metabolism and/or secondary to improved insulin sensitivity.[45,50] It should be noted, however, the only published data linking lower rates of cardiovascular disease with lower levels of plasma glucose is epidemiological.[51,52] There are no published prospective clinical trials in NIDDM demonstrating that improved glycemic control favorably impacts cardiovascular disease. It is hoped the UKPDS will address this interaction; however, according to the UKPDS Group, further long term follow-up is required to determine the precise risk benefit ratio associated with each of the current anti-diabetic therapies.[33]

During metformin monotherapy or combination therapy with a sulfonylurea, body weight stabilizes[24,26] or decreases in overweight and normal-weight patients with NIDDM.[23,30,31,38] Furthermore, NIDDM patients treated with metformin have experienced significant decreases in tissue plasminogen activator inhibitor (tPA-I)[39] and decreases in fibrinogen.[27] These secondary fibrinolytic effects of metformin could potentially result in a reduced risk of thrombosis in subjects with, or predisposed to develop, atherosclerosis.[39] However, the clinical relevance of the blood pressure changes and fibrinolytic effects has not been clearly established.

Tolerability

Metformin has shown a good safety record during millions of patient-years of use in Europe and Canada and in over three million patient-years of surveillance experience.[21,53,54] Mild transient gastrointestinal effects (diarrhea, nausea, bloating, and anorexia) are the most

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commonly reported adverse events, and fewer than 5% of patients are unable to tolerate metformin therapy for any reason.[55] Gastrointestinal adverse events such as diarrhea are typically reported at the initiation of therapy in up to 20% of patients, and can be expected to subside spontaneously within a few weeks.

Gastrointestinal discomfort can be avoided in most patients by controlled dose escalation. For example, low dosages of 500 mg once or twice daily should be used at the start of therapy and then increased slowly up the maximum dose of 2,500 mg/day.[56] Ingesting metformin with or after food may also minimize the occurrence of gastrointestinal effects. Discomfort may be ameliorated by dosage reduction and rarely necessitates treatment withdrawal.[32,45] During long term metformin treatment, only 4.2% of patients discontinued therapy because of gastrointestinal adverse effects.[38]

Approximately 3% of patients have reported an unpleasant or metallic taste in the mouth at the start of metformin therapy.[47] This metallic taste is attributed to the presence of metformin in the saliva after secretion by salivary glands[45] and usually resolves spontaneously.

Although the possibility of severe hypoglycemia is of concern during therapy with any of the sulfonylureas, metformin does not cause hypoglycemia[20] even when taken in overdose.[57] The avoidance of hypoglycemia may be partly attributed to the fact that metformin does not stimulate endogenous insulin production. While metformin does not produce hypoglycemia when used as monotherapy,[20,58] cases of hypoglycemia have been observed in general practice in patients taking concomitant sulfonylurea therapy. However, of 41 patients who developed hypoglycemia while taking a sulfonylurea in combination with another drug, only five were receiving metformin.[58] Meanwhile, in patients in whom metabolic control could not be achieved with glyburide despite at least six months of successful treatment with this agent previously, no symptomatic hypoglycemic episodes were reported with additional metformin therapy and a strictly controlled diet.[59]

Impairment of intestinal absorption of vitamin B_{12} may occur during treatment with metformin,[45] malabsorption of vitamin B_{12} was reported in 30% of patients after several years of metformin therapy.[60] Furthermore, the absorption of folate was reduced in some cases.[61] However, these effects on vitamin B_{12} and folate absorption do not appear to be clinically significant.[20,55] Only three cases of megaloblastic anemia have been reported in the literature with metformin therapy.[62-64] Subnormal levels of vitamin B_{12} appear to be rapidly reversible through vitamin B_{12} supplementation or through the discontinuation of metformin therapy. It is suggested that hematological parameters be monitored annually in patients receiving long-term metformin therapy.[56]

LACTIC ACIDOSIS

Lactic acidosis is a potentially lethal metabolic condition that may occur in association with several pathophysiological conditions when there is significant tissue hypoperfusion and hypoxemia. It is a result of overproduction of lactic acid and/or failure of the liver to remove lactate, and is characterized by decreased blood pH, elevated lactate blood levels (> 5 mmol/L), electrolyte disturbances with an increased anion gap, and an increased lactate/pyruvate ratio. Lactic acidosis has occurred rarely during metformin therapy. Metformin plasma levels of >5µg/mL are usually present when metformin is implicated as the contributing cause of lactic acidosis.

Incidence of Lactic Acidosis

Lactic acidosis during metformin therapy occurs at an incidence of approximately 0.03 cases per 1,000 patient-years (range 0-0.084 cases/1,000 patient-years). The associated mortality risk is 0.015 cases/1,000 patient-years (range 0-0.024 cases/1,000 patient-years).[20] Experience in the UK and Canada has shown that lactic acidosis can be avoided if prescribing guidelines are strictly adhered to (see Table 1).

Metformin had been in use for 330,000 patient-years between the years 1972 and 1982 in the United Kingdom without the report of a single case of lactic acidosis.[54] Similarly, metformin had been used for 56,000 patient-years in Canada without any reports of lactic acidosis.[21,65]

As of 1992, approximately 100 cases of lactic acidosis during metformin therapy had been reported worldwide, 81% of which occurred in France.[45] Data from Sweden, Switzerland, and France indicate an approximate incidence of 1 in 25,000 patient-years (see Table 2).[45]

Lactic acidosis has mostly occurred in patients with contraindications to metformin use.[20] Several conditions that predispose to the development or potentiation of lactic acidosis are common to patients with NIDDM, including diabetic nephropathy, macrovascular disease, peripheral vascular disease, and coronary heart disease. Other conditions that predispose to lactic acidosis include renal impairment, hepatic impairment, use of intravenous contrast media, hydroxylation defect, sepsis and obstructive airways disease.[55,56] A cautious approach and vigilant monitoring of a patient displaying any of these conditions is recommended to reduce the possibility of developing lactic acidosis during metformin therapy. Metformin must be immediately discontinued if hypoperfusion or hypoxemia occurs.

Table 1. Contraindications/precautions for metformin therapy.[45,55,56]

Contraindications:

- Impaired renal function
  Serum creatinine $\geq$ 1.5 mg/dL (men) or $\leq$ 1.4 mg/dL (women)
- Acute or chronic metabolic acidosis
- Intravascular radiocontrast studies
  (Stop metformin two days prior to the test and resume two days after the test)

Precautions:

- Impaired hepatic function
- Excessive alcohol intake
- Acute complications such as major surgery or severe systemic infection
  (Stop two days prior to major surgery and restart with resumption of diabetic diet)
- Severe cardiovascular or respiratory disease
- Illness resulting in hypoperfusion or hypoxemia
- Cardiovascular collapse, acute myocardial infarction
- Deficiencies of vitamin B_{12}, folic acid
- Serious dehydration
- Pregnancy

Metformin vs Phenformin

The vast majority of cases of lactic acidosis are associated with phenformin therapy.[45] Since metformin is also a biguanide, it has often been included with phenformin in the context of lactic acidosis. However, such a comparison is not warranted if the different pharmacokinetics, pharmacodynamics, and molecular structures of these agents are considered.[53]

Phenformin has a well-defined hyperlactemic effect, and the high incidence of lactic acidosis led to its withdrawal from sale in most countries in the 1970s or early 1980s, including the United States. Metformin has similar efficacy to phenformin in the treatment of patients with NIDDM, but a considerably reduced effect on lactate metabolism: the risk of lactic acidosis is calculated as approximately 10 to 100 times less than that with phenformin.[54] Of 330 published cases of biguanide-associated lactic acidosis, only 12 were associated with metformin, whereas 285 cases were associated with phenformin and 33 cases were associated with other biguanides. As demonstrated in Table 3, the risk of lactic acidosis with metformin therapy ranges from 0.016 cases per 1,000 patient-years in France to 0.07 cases per 1,000 patient-years in Switzerland. In comparison, the risk per 1,000 patient-years of phenformin therapy is in the range of 0.23 to 0.64 cases.[66] A much better prognosis has been reported for lactic acidosis with metformin compared with phenformin.

The difference in toxicity between phenformin and metformin may be explained by chemical structure and pharmacokinetic properties. Phenformin is a mono-substituted molecule with a large phenylethyl side chain and a long half-life (7.5-15 hours). It is metabolized in

Table 2. Severe adverse effects with metformin and glyburide.[53]

Drug/Adverse Event	Patient-Years of Treatment	Cases (nonfatal/fatal)	Incidence (cases/1,000 py)	Mortality rate (cases/1,000 py)
Metformin/lactic acidosis				
UK 1976-86	400,000	11 (4/7)	0.027	0.017
Switzerland 1972-77	29,800	2 (2/0)	0.067	0
Canada 1972-82	56,800	0	0	0
Sweden 1972-81	83,500	7 (5/2)	0.084	0.024
France 1984-92	2,476,061	73 (40/33)	0.03	0.013
Glyburide/hypoglycemia				
Sweden 1972-1981	300,000	57 (47/10)	0.190	0.033

py = patient-years

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the liver, with approximately 33% of an absorbed dose of phenformin being hydroxylated to an inactive metabolite. About 10% of Caucasians inherit a defect in hepatic metabolism which markedly impairs their ability to hydroxylate phenformin. Such patients are therefore considerably more vulnerable to phenformin accumulation and its hyperlactemic effects. Metformin has small methyl side chains and is not metabolized by the liver; it undergoes rapid renal excretion, with 90% being cleared in 12 hours. Phenformin binds to mitochondrial membranes with high affinity, which may account for the reduction in oxidative metabolism observed with therapy. Metformin does not bind to liver and plasma proteins and does not affect oxidative metabolism.[66]

Metformin vs Sulfonylureas

Sulfonylureas are often incorrectly considered to be a safer group of drugs for clinical use than metformin due to the commonly held misconception that the risk of developing sulfonylurea-induced hypoglycemic coma is lower than the risk of developing metformin-induced lactic acidosis. This misconception has been challenged as a result of a number of reviews on the relative benefits and risks of metformin.[21,32,45,54,66]

The incidence of hypoglycemic coma associated with sulfonylureas is probably more frequent than generally appreciated.[55] Severe sulfonylurea-induced hypoglycemia (i.e., hypoglycemic coma or hypoglycemia associated with hospitalization) has been estimated to occur at an incidence of 0.19 to 2.5 episodes per 1,000 patient-years. The average mortality rate among patients hospitalized for hypoglycemia is 10% for those receiving oral treatment versus 4% for those treated with insulin.[55]

In a retrospective comparative risk study in Sweden, the incidence of lactic acidosis during metformin therapy was significantly less than the incidence of hypoglycemic coma during therapy with the sulfonylurea glyburide. Between 1972 and mid-1981, the incidence of glyburide-induced hypoglycemic coma (0.19 per 1,000 patient-years of use) was significantly (p = 0.036) greater than the incidence of metformin-associated lactic acidosis (0.08 per 1,000 patient-years of use). The mortality risk was slightly higher for glyburide (0.033 per 1,000 patient-years) than for metformin (0.024 per 1,000 patient-years, see Table 2).[54]

Table 3. Comparative risks of lactic acidosis during therapy with phenformin and metformin.[66]

	Cases of lactic acidosis per 1,000 patient-years	
Country	**Phenformin**	**Metformin**
France	0.23	0.016
Switzerland	0.40	0.07
Sweden	0.64	0.05

Safety of Metformin Compared with Other Therapeutic Agents

Lactic acidosis is the most serious adverse event associated with metformin therapy. As noted on page 118, it is rare and has occurred almost exclusively in patients with contraindications to metformin use. The incidence of lactic acidosis with metformin therapy is similar to the incidence of serious adverse events associated with some commonly used medications. For example, the estimated incidence of thromboembolism in otherwise healthy young women who are using oral contraceptives is 0.08 per 1,000 woman-years for 37,807 woman-years of experience.[68] Anaphylactoid reactions are estimated to occur in up to two per 1,000 patients treated with penicillins. Finally, the risk of mortality due to anaphylaxis caused by penicillin is similar to the mortality risk due to metformin-induced lactic acidosis (approximately 0.01 per 1,000 patients).[69]

Thus, the safety of metformin with respect to lactic acidosis is comparable with that seen with other currently accepted drug therapies.

Elderly Patients

Metformin has been shown to be effective in the treatment of elderly patients with NIDDM.[32] It has been suggested that renal function rather than age should determine the need for caution with metformin, since renal function and plasma metformin levels are related, whereas metformin levels bear no relation to age. The drug was safely prescribed in patients older than 65 years without the occurrence of lactic acidosis when prescribing guidelines were adhered to strictly and renal function was monitored during treatment.[70] Similarly, in another study in patients aged 67 to 94 years, metformin was shown to be effective without any evidence of significant deterioration in intermediary metabolism resulting in lactate accumulation.[32]

Metformin should not be administered if there is any concern about drug accumulation or if the patient is susceptible to lactic acidosis for any reason other than age. Dosage should be individualized according to renal

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function and renal function should be carefully and regularly monitored. In addition, elderly patients should not generally be titrated to the maximum dosage of metformin. All patients taking metformin should be educated about its proper use.

CARDIOVASCULAR MORTALITY RISK

The product labeling for metformin[56] contains a warning about potential increased risk of cardiovascular mortality. The basis for this warning is the University Group Diabetes Program study, which reported that oral anti-diabetic therapy with the biguanide phenformin and the sulfonylurea tolbutamide was associated with an increased rate of cardiovascular mortality compared with the rate in patients treated with diet alone.[11] However, some diabetes specialists strongly oppose this conclusion because of several flaws in the UGDP study that may have skewed the mortality data against the oral agents.[12] Patients who died or dropped out of the study in the first year or who did not return for long periods of time were not excluded from analysis. Deaths in patients assigned to oral agents were not confirmed as being due to cardiovascular causes (of the 34 deaths in the phenformin treatment group, the cause of death was incorrectly reported in nine cases). It was not confirmed that the patient took the assigned medication as prescribed prior to the time of death (nine out of the 34 patients in the phenformin group who died had stopped taking the drug prior to their death). Patient histories and risk factors or whether the risk factors were treated or properly considered were inaccurately recorded (phenformin was contraindicated, due to current renal disease, in five of the 34 patients who were assigned to the drug and later died), and patient follow-up was poor. Approximately 20% of patients treated with oral agents were not taking their medication prior to death, and all of the deaths labeled as cardiovascular deaths were not confirmed by autopsy. Also, many of the patients who died had multiple cardiovascular risk factors, which makes it difficult to confidently ascribe their death solely to the assigned medication.[2,3,12-16] Because of the numerous criticisms of the design of the UGDP and the enormous evidence of the benefits of tight glucose control, in most cases the benefits of treatment with these agents should far outweigh any risks of cardiovascular mortality.

Conclusions

Many years of clinical experience have shown metformin to be a relatively safe and well-tolerated oral antihyperglycemic agent. The glucose-lowering effect of metformin is not associated with a stimulation of insulin secretion, and it does not cause hypoglycemia or exacerbate hyperinsulinemia, in contrast to sulfonylureas. Metformin therapy has long-term benefits in lipid homeostasis. Unlike sulfonylurea or insulin therapy, use of metformin results in weight stabilization or weight loss. Metformin is effective in lean and overweight patients. Adverse experiences are mild, transient, and gastrointestinal in origin, and can be avoided by controlled dose adjustment, and the administration of metformin with food or after a meal. Lactic acidosis is a serious and potentially fatal event that has rarely occurred during metformin therapy. However, the occurrence of lactic acidosis is less frequent than severe sulfonylurea-induced hypoglycemic coma and deaths, and has been limited primarily to patients with contraindications to metformin therapy. Renal dysfunction or illness resulting in cardiovascular collapse, hypoxia and/or hypoperfusion are the primary precipitating events in metformin-associated lactic acidosis. The risk of lactic acidosis can be minimized as long as the contraindications are respected, the prescribing guidelines are followed closely, and the patients are monitored for any signs of concurrent illness that could increase the risk of lactic acidosis.

Metformin, therefore, is a well-tolerated and effective antihyperglycemic therapy for patients with NIDDM not controlled by diet alone when prescribed within the recommended guidelines. Metformin can also be used as combination therapy with sulfonylurea agents to achieve additional blood sugar lowering.

The introduction of metformin (Glucophage®) to the market in the United States has markedly improved our ability to achieve normalization of blood sugar and improve the lipid profile in type II diabetes. I recommend the cornerstone of therapy in type II diabetes to be as follows:

Cornerstone of Therapy

1. Diabetic meal plan designed to achieve or maintain desirable body weight — three meals and three snacks — 4 g sodium, low cholesterol;
2. Exercise designed within the patient's limits;
3. Self-monitoring of blood glucose by all diabetic patients — usually two to six determinations per day depending on the degree of blood sugar control;
4. Sulfonylurea agents and/or metformin prescribed to achieve normalization of blood sugar — HbA_{1c} 7.0% or less;
5. FBG below 140 mg/dL on successive determinations with dietary adherence, and a glycohemoglobin below 7.0%, otherwise insulin therapy in at least two and usually three injections per day;

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6. The use of a combination of oral anti-diabetic agents — sulfonylurea and/or metformin and/or precose and/or insulin — to achieve normalization plus reduction or maintenance of blood pressure and lipids in normal range (Metformin has been approved for use in combination therapy with sulfonylureas but not with insulin);
7. Attainment of blood sugar normalization plus reduction or maintenance of blood pressure and lipids in normal range;
8. Cessation of tobacco use and, if used, alcohol in moderation;
9. Continued physician and health care personnel education.

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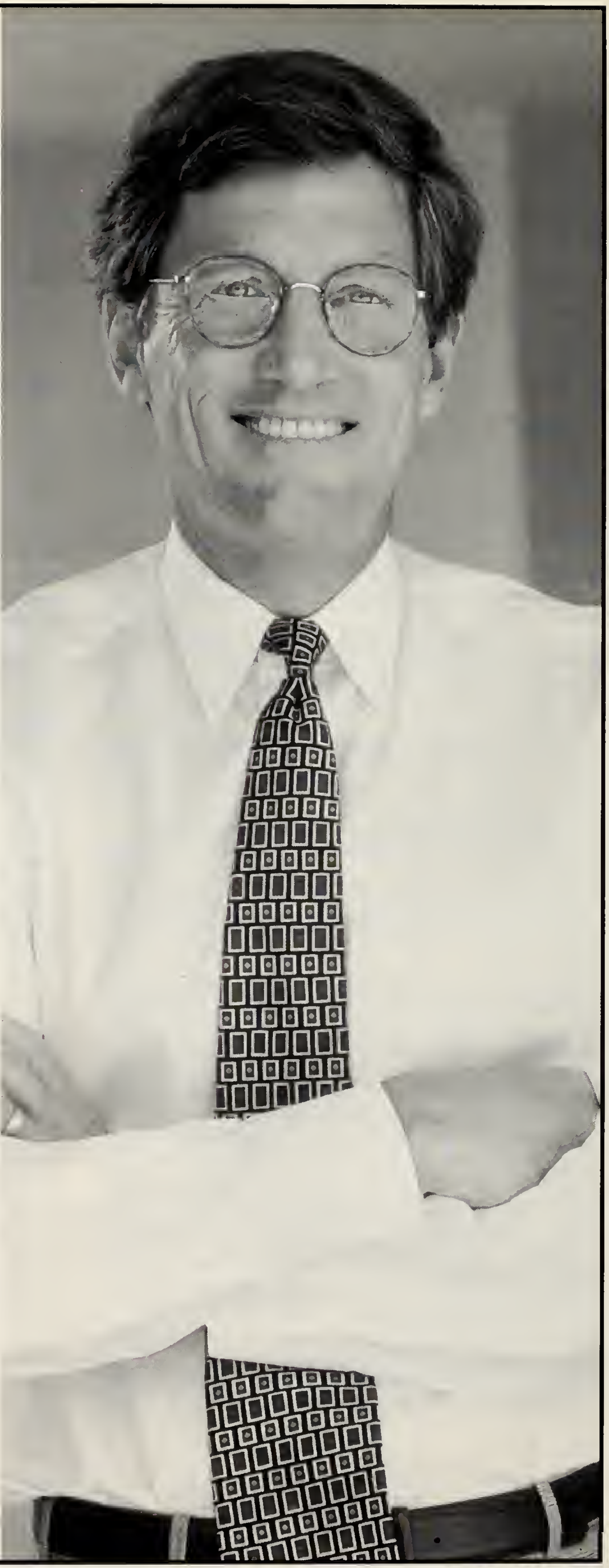

REPORT OF
MISSOURI STATE MEDICAL ASSOCIATION

December 31, 1996
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Council of
Missouri State Medical Association:

We have audited the accompanying Statement of Financial Position of Missouri State Medical Association as of December 31, 1996 and 1995, and the related Statement of Activities, Statement of Changes in Net Assets, and Statement of Cash Flows for the years then ended. These Financial Statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We did not examine the Financial Statements of MOMED Holding Company at December 31, 1996 and 1995. These Financial Statements were audited by another firm.

These Financial Statements are not in accordance with Generally Accepted Accounting Principles, which require investments in the subsidiaries to be consolidated with the controlling entity.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe our audits provide a reasonable basis for our opinion.

In our opinion, except for the above comments, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association as of December 31, 1996 and 1995, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

Our audits were made for the purpose of forming an opinion on the basic Financial Statements taken as a whole. The Schedules of Selected Expenses for the years ended December 31, 1996 and 1995, are presented for purposes of additional analysis and are not a required part of the basic Financial Statements. Such information has been subjected to the auditing procedures applied in the audit of the basic Financial Statements and, in our opinion, is fairly stated in all material respects in relation to the basic Financial Statements taken as a whole.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 23, 1997

STATEMENT OF FINANCIAL POSITION
December 31, 1996 and 1995

	1996	1995
ASSETS		
CURRENT ASSETS		
Cash and Cash Investments (Note 2)	$ 759,193	$ 294,787
Marketable Securities (Note 3)	1,606,560	1,317,430
Accounts Receivable	85,658	39,730
Other Current Assets	9,190	4,816
Total Current Assets	2,460,601	1,656,763
INVESTMENTS		
Common Stock of MAIC Holdings, Inc. (Note 5)	1,798,043	0
Common Stock of MOMED Holding Company a 10.8% owned Affiliate, (Note 5)	0	169,295
Common Stock of Missouri State Medical Services, Inc. (Note 13)	(212,741)	(149,628)
Common Stock of MSMI, Inc. (Note 4)	18,085	35,288
Total Investments	1,603,387	54,955
LAND, BUILDING AND EQUIPMENT (Note 6)	497,318	495,249
OTHER ASSETS		
Cash Surrender Value - Insurance	32,429	24,058
Note Receivable, Missouri State Medical Services, Inc. (Note 14)	202,767	185,630
Interest Receivable, Missouri State Medical Services, Inc.	19,230	16,702
Total Other Assets	254,426	226,390
TOTAL ASSETS	$4,815,732	$2,433,357
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable and Accrued Expenses	$ 6,747	$10,034
Dues to the American Medical Association	146,658	197,840
Deferred Revenue	193,191	230,594
Total Current Liabilities	346,596	438,468
DEFERRED COMPENSATION (Note 8)	20,000	15,000
Total Liabilities	366,596	453,468
UNRESTRICTED NET ASSETS	4,449,136	1,979,889
TOTAL LIABILITIES AND NET ASSETS	$4,815,732	$2,433,357

The Notes to Financial Statements are an integral part of these Statements.

MSMA Financial Statements

STATEMENT OF ACTIVITIES
For the Years Ended December 31, 1996 and 1995

	1996	1995
REVENUES		
Dues	$1,144,570	$1,184,433
Subscriptions	20,411	17,711
Exhibit Rentals	31,000	33,700
Advertising	56,605	45,318
Commissions on Collections	13,266	14,329
Investment Income (Note 9)	824,478	263,667
Administrative Fees and Office Rent (Note 10)	107,963	55,848
Seminars and Workshops	12,450	13,585
Physicians' Health Foundation (Note 11)	174,895	141,475
Royalties (Note 15)	65,237	60,659
Unrealized Gain on Equity Investments (Note 1)	1,752,696	0
Other Revenue	60,868	39,835
Total Revenues	4,264,439	1,870,560
EXPENSES		
Salaries and Fringe Benefits	$ 617,089	$ 762,881
Office Expense (Note 16)	137,490	132,355
Travel Expense	11,401	11,498
Commissions and Committee Expense	10,925	7,459
Depreciation	35,623	30,455
MSMA Alliance	11,789	9,353
Journal Expense	94,370	95,635
Meeting Expense	216,747	247,782
Public Affairs	77,483	91,604
Consultant and Professional Fees	48,588	69,520
Public Relations Program	54,310	29,998
Student Awards	1,200	1,200
Tort Reform	4,500	5,000
Miscellaneous	7,943	7,706
Seminars and Workshops	24,706	16,817
Physicians' Health Foundation (Note 11)	$ 204,902	$ 172,228
MSMA Health Education Foundation	77,131	187,870
Missouri State Medical Foundation	78	161
Excess Subordinated Notes	0	4,317
Total Expenses	1,636,275	1,883,839
Increase (Decrease) in Unrestricted Net Assets Before Equity in Net Income of Investments	$2,628,164	$ (13,279)
Equity in Subsidiary of MSMI, Inc. (Note 4)	(17,203)	1,473
Equity in Subsidiary of MSMS, Inc. (Note 13)	(63,113)	(54,589)
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	$2,547,848	$ (66,395)

STATEMENT OF CHANGES IN NET ASSETS
For the Years Ended December 31, 1996 and 1995

	1996	1995
UNRESTRICTED NET ASSETS		
Total Unrestricted Revenues and Gains	$4,264,439	$1,870,560
Total Unrestricted Expenses	1,716,591	1,936,955
Decrease Arising from Change in Equity Investment Valuation	78,601	0
Change in Unrestricted Net Assets	2,469,247	(66,395)
NET ASSETS, BEGINNING	1,979,889	2,046,284
NET ASSETS, ENDING	$4,449,136	$1,979,889

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STATEMENT OF CASH FLOWS
For the Years Ended December 31, 1996 and 1995

	1996	1995
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Unrestricted Net Assets	$2,547,848	$(66,395)
ADJUSTMENTS TO RECONCILE CHANGE IN NET ASSETS TO NET CASH PROVIDED BY OPERATING ACTIVITIES:		
Depreciation	35,632	30,455
Loss on Disposal of Equipment	220	879
(Increase) or Decrease in Accounts Receivable	(45,928)	(6,305)
(Increase) or Decrease in other Current Assets	(4,374)	1,428
(Increase) or Decrease in Cash Surrender Value	(8,371)	78,389
(Increase) or Decrease in Note Receivable, MSMS, Inc.	(17,136)	(35,133)
(Increase) or Decrease in Interest Receivable, MSMS, Inc.	(2,528)	(16,702)
Increase or (Decrease) in Accounts Payable	(3,287)	(19,594)
Increase or (Decrease) in Dues to the AMA	(51,182)	88,343
Increase or (Decrease) in Deferred Revenue	(37,403)	81,051
Increase or (Decrease) in Deferred Compensation	5,000	(58,500)
Total Adjustments	(129,357)	144,311
Net Cash Provided by Operations	2,418,491	77,916
CASH FLOW FROM INVESTING ACTIVITIES:		
(Increase) or Decrease in Marketable Securities	$(289,130)	$ 291,046
(Increase) Decrease in Common Stock of MOMED Holding Co., net of adjustment to revalue	90,694	0
(Increase) Decrese in Common Stock of MAIC Holdings, Inc.	(1,798,043)	0
(Increase) or Decrease in MSMI, Inc. Investment	17,203	(1,473)
(Increase) or Decrease in MSMS, Inc. Investment	63,113	54,589
Purchase of Equipment	(37,922)	(31,855)
Net Cash Used Investing	(1,954,085)	312,307
CASH FLOW FROM FINANCING ACTIVITIES		
Decrease in Subordinated Notes Payable	0	(590,781)
Net Cash Used by Financing Activities	0	(590,781)
NET INCREASE OR (DECREASE) IN CASH	464,406	(200,558)
CASH AT BEGINNING OF YEAR	294,787	495,345
CASH AT END OF YEAR	$ 759,193	$ 294,787

NOTES TO FINANCIAL STATEMENTS
December 31, 1996 and 1995

Note 1.Summary of Significant Accounting Policies

Organization:
The Missouri State Medical Association was incorporated as a not-for-profit corporation under the laws of the State of Missouri. The Internal Revenue Service has granted exemption under Code Section 501 (c)(6).

Basis of Accounting:
The Financial Statements of the Missouri State Medical Association are prepared on the Accrual Basis of Accounting.

Dues:
Dues are assessed to members on a calendar-year basis. On December 31st of each year, members delinquent in payment of dues forfeit their memberships. The Association may also collect from members dues and assessments of the American Medical Association and Component Medical Societies which are then forwarded to the respective organizations. The Association receives a fee for providing this service. Amounts received from members prior to January 1st of each year, which represents the subsequent year's dues, are recorded as Deferred Revenue.

Valuation of Accounts Receivable:
Accounts receivable are stated at face amount with no allowance for doubtful accounts. An allowance for doubtful accounts is not considered necessary because probable uncollectible accounts are immaterial.

Marketable Securities:
Investments in marketable equity securities are carried at the lower of aggregate cost or market at the Balance Sheet date.

Property and Equipment:
Property and equipment are carried at cost. Depreciation is computed by the straight-line method based on estimated useful lives of the related assets.

Income Taxes:
The Association is exempt from Federal Income Taxes under the Internal Revenue Code Section 501 (c)(6). Any unrelated business income is subject to income tax.

Financial Statement Presentation:
In 1996, Missouri State Medical Association adopted Statement of Financial Accounting Standards (SFAS) No. 117 "Financial Statement of Not-For-Profit Organizations." Under SFAS No. 117, Missouri State Medical Association is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Missouri State Medical Association also adopted SFAS No. 116 "Accounting for Contributions Received and Contributions Made" in 1996. In accordance with SFAS No. 116, contributions received are recorded as unrestricted, temporarily restricted, or permanently restricted support depending on the existence and/or nature of any donor restrictions. The adoption of SFAS No. 116 had no effect on net assets or the change in net assets as of or for the year ended December 31, 1996. In addition Missouri State Medical Association has not received any contributions with donor-imposed restrictions that would result in temporarily or permanently restricted net assets.

In 1996, Missouri State Medical Association adopted SFAS No. 124 "Accounting for Certain Investments Held by Not-For-Profit Organizations." That statement provides, in part, that investments in equity securities with readily determinable fair value should be reported at their fair value. Further required, is recognition of unrealized gains and losses when such investments are carried at fair value.

Note 2. Cash and Cash Investments

The balance of cash and cash investments consisted of the following at December 31st:

	1996	1995
Petty Cash	$ 50	$ 50
Cash in Bank, EVP Account	8,804	6,178
Cash in Bank, Treasury Account	4,829	170,879
Money Market Fund	454,310	117,680
Certificates of Deposit	291,200	0
TOTAL CASH	$759,193	$294,787

Note 3. Marketable Securities

Investments in marketable equity securities are carried at the lower of aggregate cost or market at the Balance Sheet date.

The following is a summary of marketable equity securities at December 31st:

	1996	1995
Aggregate Cost	$1,606,560	$1,317,430
Aggregate Market	2,428,569	1,738,958
UNREALIZED GAIN	$ 822,009	$ 421,528

Net realized gain of $61,015 and $149,890 on the sale of marketable equity securities were included in revenue for the years ended December 31, 1996 and 1995, respectively.

Note 4. Investments in Unconsolidated Subsidiary - MSMI, Inc.

The Association's investments in MSMI, Inc., a 100% owned unconsolidated subsidiary, is carried at cost $2,000 plus equity in the undistributed net earnings since the date of acquisition. At December 31, 1996 and 1995, the investment in the subsidiary is carried at $38,085 and $37,288 respectively.

Condensed financial data relating to the subsidiary follows:

BALANCE SHEETS

	---December 31---	
	1996	1995
ASSETS		
CURRENT ASSETS		
Cash, including Savings Account	$ 23,085	$ 22,288
Total Current Assets	23,085	22,288
INVESTMENTS - COMMON STOCK	15,000	15,000
TOTAL ASSETS	$ 38,085	$ 37,288
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable	$20,000	$ 2,000
STOCKHOLDERS' EQUITY		
Common Stock, $10 par value: 3000 shares authorized; 200 shares issued and Outstanding	2,000	$ 2,000
Retained Earnings	16,085	33,288
Total Stockholders' Equity	18,085	35,288
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$38,085	$37,288

STATEMENTS OF INCOME AND EXPENSES

Income	$ 4,265	$ 4,821
Expenses	21,468	3,348
NET INCOME (LOSS)	$(17,203)	$ 1,473

Note 5. Investments

At December 31, 1995, the Association owned 24,185 shares of MOMED Holding Company Class A common stock (500,000 shares authorized), and 24,185 shares of MOMED Holding Company Class C common stock. The Class A common stock carries voting rights. The Class C common stock is non-voting. In January 1996, a two for one split occurred with the Class A common stock yielding an additional 48,370 shares for a total of 72,555 shares of Class A common stock in MOMED Holding Company.

In September, 1996, MOMED Holding Company, by prior agreement, redeemed the entire 24,185 shares of Class C common stock held by the Association at $24.81 per share for a total of $600,000.

Note 5. Investments (Continued)

During December 1996, MOMED Holding Company merged with MAIC Holdings, Inc. MAIC Holdings is headquartered in Birmingham, Alabama where it began operations in April 1977 as Mutual Assurance, a mutual insurer operating solely in the state of Alabama. The company converted to a public, stock insurer in September 1991, and formed its holding company, MAIC Holdings, Inc. in August 1995. The company's stock now trades on the New York Stock Exchange under the symbol MAI

As a result of the merger, at December 31, 1996, the Association owns 56,520 shares of MAIC Holdings, Inc. On December 31, 1996, MAIC Holdings Inc. closed on the New York Stock Exchange at 31 13/16, thus assigning the market value of $1,798,043. Market value of the shares at December 31, 1995 was $169,295. The substantial increase is primarily the result of a 2 for 1 stock split in MOMED Holding Company during the year and the conversion to a public stock rather than an essentially closed corporation resulting in limited salability.

Note 6. Land, Building and Equipment

Consists of the following at December 31st (at Cost):

	1996	1995
Land	$ 83,000	$ 83,000
Building	581,704	581,704
Furniture and Equipment	240,633	244,362
Total	905,337	909,066
LESS: Accumulated Depreciation	408,019	413,817
TOTAL LAND, BUILDING AND EQUIPMENT	$497,318	$495,249

Note 7. Subordinated Notes Payable

In 1978, the Association formed a wholly-owned subsidiary, MOMEDICO, to provide professional liability and premises liability insurance for physicians and support technicians practicing in the State of Missouri. Before obtaining professional liability insurance through MOMEDICO, physicians residing in the State of Missouri were required to subscribe to non-interest bearing subordinated notes based upon the physician's underwriting classification. These notes were issued by the Association and the subscriptions were payable over a three-year period.

The Association was the sole stockholder of MOMEDICO prior to public stock offering of MOMEDICO in 1980. At that time, the requirement to purchase subordinated notes was eliminated with new policies effective January 31, 1980.

In connection with the public stock offering in 1980, MOMEDICO assumed, in exchange for 100,815 of the 125,000 shares of the Class B common stock the Association held in MOMEDICO, the face value of the subordinated notes issued and outstanding. MOMEDICO also assumed the balance of the installments receivable on the subordinated notes and a bank note payable from the Association.

Under an exchange offer made by MOMEDICO, holders of the Association's subordinated note could exchange fully paid notes for Class A common stock at the rate of $20 face value per share.

On October 15, 1980, the Association reassumed all notes not exchanged and also the installments receivable on the unexchanged notes as well as an amount equal to the installments receivable of the bank note payable.

The notes require repayment only upon the Association's accumulation of an excess of $3,000,000 of Net Assets at the end of any calendar year, that the Association has sufficient funds and assets, exclusive of the amount subject to repayment, and that repayment be approved by the Council of the Association.

Interest may be paid on the notes, but it is at the discretion of the Council of the Association.

Redemption of the notes are provided for in the event of death, disability, retirement of the holder, or if the holder has moved both his/her person and his/her practice out of the State of Missouri. However, redemption for such causes may be delayed or refused if the Council determines the Association is not on a financially reasonable basis to make such redemptions.

At December 31, 1994, the balance for the subordinated notes payable was $590,781. This amount reflects the face value of the notes reassumed by the Association on October 15, 1980, less the installments receivable on the outstanding notes, and less all redemptions made from 1981 through 1985. In 1985, the Council of the Association placed a moratorium on the redemption of the subordinated notes.

On August 10, 1995, Missouri State Medical Association transferred approximately $590,000 to an earlier established irrevocable Missouri State Medical Association Trust including the mandate to satisfy all subordinated notes payable to member physicians. Any monies remaining, after a two-year period, are to be donated to the Missouri State Medical Foundation.

Note 8. Deferred Compensation Plan

The Association entered into a deferred compensation agreement with its Executive Vice-President on May 1, 1990, which provides for payments upon retirement, death or disability. The agreement also stipulates that a pro-rata settlement of benefits will be made in the event of voluntary termination of employment with the Association once five years of service is completed after the agreement becomes effective.

Note 8. Deferred Compensation Plan (Continued)

The agreement is funded through an insurance policy.

At December 31, 1996 and 1995, the Association's liability under the terms of these agreements were $20,000 and $15,000, respectively with the underlying cash surrender value of life insurance being $32,429 and $24,058, respectively.

On December 17, 1989, the Association adopted a Deferred Compensation Plan for employees pursuant to Internal Revenue Service Code Section 457. Within Internal Revenue Service guidelines, participants may elect to defer a portion of their income until retirement. Funds invested for these purposes amounted to $193,121 and $158,821 as of December 31, 1996 and 1995, respectively.

Note 9. Investment Income

The following is a summary of investment income for the years ended December 31st:

	1996	1995
Interest on Cash Investments	$ 25,231	$ 28,210
Dividends	56,473	64,072
Realized Gain or (Loss) on the Sale of Marketable Equity Securities	61,015	149,890
Interest on Note to Subsidiary	19,229	21,495
Interest from MOMED Stock Sale	107,877	0
Gain on Sale of MOMED Stock (sale price $600,000 less cost $45,347)	554,653	0
TOTAL INVESTMENT INCOME	$824,478	$263,667

Note 10. Related Party Transactions

The Association provides administrative services to MSMI, Inc., (a wholly-owned subsidiary) and Missouri State Medical Foundation (an affiliate). For providing these services, the Association receives an annual fee from each of these two organizations. For the years ended December 31, 1996 and 1995, the annual administrative fee assessed to Missouri State Medical Foundation was $21,000 and $18,000 respectively, and the administrative fee assessed to MSMI, Inc., was $20,000 and $2,000 respectively.

Note 11. Physicians' Rehabilitation Program

In 1986, the Association established a Physicians' Rehabilitation Program, the purpose of which is to motivate impaired physicians to voluntarily enter into treatment and to provide such a treatment program.

Funding for the program is provided by fees assessed to participants as well as from donations received from supportive individuals and organizations.

During 1992, the Missouri State Medical Association Physicians' Health Foundation was separately incorporated. For the years ended December 31, 1996 and 1995, the Association received as income $174,895 and $141,475 from the Physicians' Health Foundation and in turn paid expenses of $204,902 and $172,228, respectively. The resulting differences of $30,000 and $30,753 are considered in-kind contributions to the Physicians' Health Foundation for the years ended December 31, 1996 and 1995.

Note 12. Pension Plan

The Association maintains a non-contributory Defined Benefit Pension Plan covering substantially all of its employees. Established April 1, 1959, the Plan has a March 31st year end. Eligibility requirements include a minimum of 12 service months and a minimum age of 21. Normal retirement age is 65 with provision for pro-rata benefits prior to 65. Vesting is scheduled over six years of covered service. The Individual Aggregate Actuarial Cost Method is used as the basis for the funding standard account computation. At March 31, 1996, the most recently available actuarial information, fair value of plan assets was $305,261 and $343,616, in 1995. Total benefit obligation for 1996 was $689,003 and $1,108,229 in 1995 with a vested benefit obligation for 1996 of $676,403 and $1,096,969, in 1995.

Employer contributions for FYE March 31, 1996 was $76,229, $115,526, in 1995. Additional Plan income for 1996 was $42,542 and $12,111, in 1995, with expenses for 1996 of $128 and $194 in 1995, and benefits paid for 1996 in the amount of $156,998 and $638,835 in 1995, and net income (loss) for Plan year 1996 was $(38,355) and $(511,392), in 1995. There was no unconditional liability for any unfunded accumulated benefit obligation plus any prepaid pension cost, nor unfunded accumulated benefit obligation reduced by any unfunded accrued pension cost. Assets are invested primarily in government securities and corporate stocks and bonds.

Net periodic pension costs for 1996 of $78,648, $117,583, in 1995, was composed of employer's normal cost for 1996 of $72,349 and $107,131 in 1995, amortization charge for 1996 of $234 and $233 in 1995, and interest for 1996 of $6,065 and $8,589, in 1995.

On January 1, 1995, the Executive Vice President retired, with the Executive Director assuming the position of Executive Vice President on January 1, 1995.

Note 13. Investment in Unconsolidated Subsidiary - MSMS, Inc.

The Association's investments in MSMS, Inc., a 100% owned unconsolidated subsidiary, is carried at cost of $30,000 plus equity in the undistributed net earnings since the date of acquisition. At December 31, 1996 and 1995, the investment in the subsidiary is carried at $(212,741) and $(149,628) respectively.

Note 13. Investment in Unconsolidated Subsidiary - MSMS, Inc. (Continued)

Condensed financial data relating to the subsidiary follows:

BALANCE SHEETS

	1996	1995
ASSETS		
CURRENT ASSETS		
Cash	$ 7,529	$ 40,371
Accounts Receivable, net	28,840	14,746
Employee Advances	500	500
Total Current Assets	36,869	55,617
PROPERTY AND EQUIPMENT		
Office Furniture and Equipment	3,460	3,460
LESS: Accumulated Depreciation	(1,730)	(1,038)
Total Property and Equipment	1,730	2,422
TOTAL ASSETS	$38,599	$ 58,039
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Notes Payable (Note 3)	$202,767	$185,630
Accounts Payable	26,743	2,735
Accrued Expenses	2,600	2,600
Interest Payable	19,230	16,702
Total Current Liabilities	251,340	207,667
STOCKHOLDERS' EQUITY		
Common Stock, $1 par value: 30,000 Shares authorized; 30,000 Shares issued and outstanding	30,000	30,000
Retained Earnings	(242,741)	(179,628)
Total Stockholders' Equity	(212,741)	(149,628)
TOTAL LIABILITIES AND STOCKHOLDERS'EQUITY	$ 38,599	$ 58,039

STATEMENTS OF INCOME AND EXPENSES

	1996	1995
Income	$144,166	$166,509
Expenses	207,279	221,098
NET INCOME (LOSS)	$(63,113)	$(54,589)

Note 14. Note Receivable, Missouri State Medical Services, Inc.

The note represents monies advanced by Missouri State Medical Association to Missouri State Medical Services, Inc. for initial expenses. The note is a demand note in the amount of $202,766 and $185,630 at December 31, 1996 and 1995, respectively, with interest at the rate of 9.5% in 1996 and 1995. The interest rate adjusts annually on January 1st to the prime rate plus 1%.

Note 15. Royalties

Royalty income is received from Missouri Medical Insurance Co. for use of the Missouri State Medical Association name and various logos in the marketing and advertisement of its professional liability insurance and risk management products. For the year ended December 31, 1996 and 1995, royalty income received from Missouri Medical Insurance Co. was $35,000 annually.

An additional royalty of $20 per Missouri Medical Insurance Co. insured physician in the State of Missouri as of December 31st of each preceding year, is to be paid on or before February 15th of the following year. At December 31, 1996 and 1995, royalty income receivable totaled $20,000 and $22,180 respectively.

Note 16. Operating Lease - Automobile

The following is a schedule, by year, of future minimum rental payments required under an operating lease for the rental of an automobile that has an initial or remaining noncancelable lease term in excess of one year as of December 31, 1996:

Years ending December 31st:

1997	$1,537
Total	$1,537

Total rental expense for the year ending December 31, 1996, totaled $6,149.

ACCOMPANYING INFORMATION

SCHEDULES OF SELECTED EXPENSES
For the Years Ended December 31, 1996 and 1995

	1996	1995
SALARIES AND FRINGE BENEFITS		
Salaries	$433,466	$474,412
Payroll Taxes	34,820	38,560
Employee Life and Disability Insurance	16,964	13,846
Employee Hospitalization Insurance	42,960	51,387
Employee Pension Plan Contribution	52,950	123,237
Deferred Compensation Plan Expense	35,929	46,439
TOTAL SALARIES AND FRINGE BENEFITS	$ 617,089	$747,881
OFFICE EXPENSES		
Occupancy Expense	$ 15,938	$ 17,579
Office Supplies	21,790	19,037
Computer Expense	4,680	6,672
Postage	19,817	21,691
Telephone	17,137	16,505
Insurance	5,634	9,156
General Expense	0	(2,554)
Taxes, Real Estate	4,020	3,994
Taxes, Other	504	942
Custodian Fee	16,088	14,957
Equipment Rental and Repair	13,708	14,505
Dues and Directories	18,174	9,871
TOTAL OFFICE EXPENSES	$137,490	$132,355

	1996	1995
COMMISSIONS AND COMMITTEES EXPENSES		
Commissions:		
Commission on Medical Economics	$ 537	$ 60
Commission on Continuing Medical Education	10,000	7,049
Commission on Interspeciality Medicine	0	350
Total Commissions Expenses	10,575	7,459
COMMISSIONS AND COMMITTEES EXPENSES		
Committees:		
Committee on Legislative Affairs	$ 58	$ 0
Committee on Medical Legal	292	0
Total Committee Expenses	350	0
TOTAL COMMISSIONS AND COMMITTEE EXPENSES	$ 10,925	$ 7,459
MEETING EXPENSES		
Meetings:		
Annual Session	$ 70,528	$ 67,531
Council	58,666	75,436
AMA Delegates' Expenses	80,987	100,781
Student Section	2,940	1,396
Resident Physician Section	149	0
Discretionary Council Fund	3,130	1,714
Hospital Medical Staff	347	924
TOTAL MEETING EXPENSES	$216,747	$247,782

To the Council of
Missouri State Medical Association:

In planning and performing our audits of the Financial Statements of Missouri State Medical Association for the years ended December 31, 1996 and 1995, we considered its internal control structure in order to determine our auditing procedures for the purpose of expressing our opinion on the Financial Statements and not to provide assurance on the internal control structure. We noted no matters involving the internal control structure and operations that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operations of the internal control structure that, in our judgement, could adversely affect Missouri State Medical Association's ability to record, process, summarize, and report financial data consistent with the assertions of management in the Financial Statements.

A material weakness is a reportable condition in which the design or operation of one or more of the internal control structure elements does not reduce, to a relatively low level, the risk of errors or irregularities in amounts that would be material in relation to the Financial Statements being audited may occur and not be detected within a timely period by employees in the normal course of work performing their assigned functions.

Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses as defined above. No reportable conditions as described above were found.

This report is intended solely for the information and use of Missouri State Medical Association, management, and others within the Organization.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 23, 1996

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REPORT OF MISSOURI STATE MEDICAL FOUNDATION

December 31, 1996
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Foundation:

We have audited the accompanying Statement of Financial Position of Missouri State Medical Foundation as of December 31, 1996 and 1995, and the related Statement of Activities, and Changes in Net Assets and Statement of Cash Flows for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Foundation as of December 31, 1996 and 1995, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 23, 1997

STATEMENT OF FINANCIAL POSITION
December 31, 1996 and 1995

	1996	1995
ASSETS		
CURRENT ASSETS		
Cash and Equivalents (Note 2)	$ 526,192	$ 490,611
Investments (Note 3)	783,037	707,856
Loans Receivable, Current (Note 4)	250,000	250,000
Accrued Interest	8,393	14,311
Total Current Assets	1,567,622	1,462,788
LONG-TERM ASSETS		
Loans Receivable, Long-term (Note 4)	1,507,425	1,442,321
Total Long-term Assets	1,507,425	1,442,321
EQUIPMENT		
Office Equipment, Net	5,166	1,613
Software, Net	6,766	8,905
Total Equipment	11,932	10,518
TOTAL ASSETS	$3,086,979	$ 2,915,617
NET ASSETS		
UNRESTRICTED NET ASSETS	$3,086,979	$ 2,915,617

STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
For the Years Ended December 31, 1996 and 1995

	1996	1995
REVENUES		
Interest on Student Loans	$ 124,088	$ 145,219
Investment Income	81,018	65,263
Contributions	675	95
Gain on Sales of Securities	18,606	(848)
Total Revenues	224,387	209,729
EXPENSES		
Administrative	21,000	18,000
Professional Fees	2,516	2,427
Printing and Meeting	794	814
Provision for Loan Losses	21,983	19,086
Depreciation	1,228	412
Amortization	2,138	1,685
Bank Fees	2,644	5,448
Miscellaneous	722	1,098
Total Expenses	53,025	48,970
INCREASE IN UNRESTRICTED NET ASSETS	171,362	160,759
NET ASSETS, BEGINNING	2,915,617	2,754,858
NET ASSETS, ENDING	$3,086,979	$2,915,617

The Notes to Financial Statements are an integral part of these Statements.

STATEMENT OF CASH FLOWS
INDIRECT METHOD
For the Years Ended December 31, 1996 and 1995

	1996	1995
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in Unrestricted Net Assets	$171,362	$160,759
Adjustment to reconcile Change in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation and Amortization	3,366	2,097
(Increase) Decrease in Accrued Interest	5,918	(14,311)
Total Adjustments to Reconcile Change in Net Assets to Net Cash	9,284	(12,214)
Net Cash Provided by Operating Activities	180,646	148,545
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Office Equipment	(4,781)	(167)
Purchase of Software	0	(4,538)
Purchase and Sale of Investments, Net of gains and losses	(75,180)	(146,957)
Net Cash Used by Investing Activities	(79,961)	(151,662)
CASH FLOWS FROM FINANCING ACTIVITIES		
Increase in Loans Receivable, net of Allowance For Doubtful Accounts	(65,104)	(29,509)
Net Cash Used in Financing Activities	(65,104)	(29,509)
Net Increase in Cash and Cash Equivalents	35,581	(32,626)
CASH AND CASH EQUIVALENTS, BEGINNING	490,611	523,237
CASH AND CASH EQUIVALENTS, ENDING	$526,192	$490,611

NOTES TO FINANCIAL STATEMENTS
December 31, 1996 and 1995

Note 1.Summary of Significant Accounting Policies

Organization:

Missouri State Medical Foundation was organized in 1961 for the purpose of making low-interest loans to medical students.

Basis of Accounting:

The Financial Statements of Missouri State Medical Foundation are prepared on the Accrual Basis of Accounting.

Loans Receivable:

Loans receivable are stated at face amount less an allowance for doubtful accounts of five percent of the loan balances at December 31, 1996 and four percent of loan balances at December 31, 1995.

Income Taxes:

The Foundation is qualified as an exempt organization under Section 501 (c)(3) of the Internal Revenue Code and is not subject to Federal or State Income Tax.

Financial Statement Presentation:

In 1996, Missouri State Medical Foundation adopted Statement of Financial Accounting Statndards (SFAS) No. 117 "Financial Statement of Not-For-Profit Organizations." Under SFAS No. 117, Missouri State Medical Foundation is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Missouri State Medical Foundation also adopted SFAS No. 116 "Accounting for contributions Received and Contributions Made" in 1996. In accordance with SFAS No. 116, contributions received are recorded as unrestricted, temporarily restricted, or permanently restricted support depending on the existence and/or nature of any donor restrictions. The adoption of SFAS No. 116 had no effect on net assets or the change in net assets as of or for the year ended December 31, 1996. In addition, Missouri State Medical Foundation has not received any contributions with donor-imposed restrictions that would result in temporarily or permanently restricted net assets.

Note 2. Cash and Equivalents

Cash and equivalents consist primarily of Cash, Government Issues and Taxable Bonds with maturities of one year or less. Cash and equivalents are stated at cost plus accrued interest, which approximates market value.

Cash and equivalents include the following accounts:

	1996	1995
Cash in Bank, Checking	$ 32,487	$ 4,511
Money Market	105,398	36,656
Government Issues	248,031	104,281
Taxable Bonds	140,276	345,163
TOTAL CASH AND EQUIVALENTS	$526,192	$490,611

Note 3. Investments

At December 31, 1996 and 1995, the Foundation's investments consist of Government Issues and Mortgage and Asset-backed Issues all having maturities in excess of one year, and a Mutual Fund Portfolio. Government Issues and Bonds are stated at cost plus accrued interest, which approximates market value. Mortgage and Asset-backed Issues are stated at cost less principle payments made to date, to approximate market value. The Mutual Fund Portfolio is valued at cost plus reinvested interest and dividends.

Investements include the following accounts:

	1996	1995
Government Issues	$101,429	$349,461
Mortgage & Asset Backed Issues	577,441	134,662
Taxable Bonds	0	140,276
Mutual Funds	104,167	83,457
TOTAL INVESTMENTS	$783,037	$707,856

Note 4. Loans Receivable

The following is a summary of the transactions affecting the loans receivable account for the year:

Loans Receivable, Beginning of Year	$1,762,834	$1,714,239
New Loans	267,830	273,480
Principle Payments	(180,743)	(224,885)
Loans Written Off	0	0
LOANS RECEIVABLE, END OF YEAR	$1,849,921	$1,762,834
Allowance for Doubtful Accts, Beginning of Year	$ 70,513	$ 51,427
Current Year Provision	21,983	19,086
Loans Written Off	0	0
ALLOWANCE FOR DOUBTFUL ACCOUNTS, END OF YEAR	$ 92,496	$ 70,513

Note 5. Equipment

Office equipment is recorded at cost and depreciated over its estimated useful life on a straight-line basis.

Intangible assets, such as software, are recorded at cost and amortized over a 60-month period on a straight-line basis.

Equipment at Cost	$ 6,939	$ 2,158
LESS: Accumulated Depreciation	1,773	545
BOOK VALUE	$ 5,166	$ 1,613
Software at Cost	$10,692	$10,692
LESS: Accumulated Depreciation	3,926	1,787
BOOK VALUE	$ 6,766	$ 8,905

Note 6. Related Party Transactions

The Foundation is assessed by the Missouri State Medical Association an annual fee for administrative cost. For the years ended December 31, 1996 and 1995, the Foundation paid the Association $21,000 and $18,000 respectively, for administrative costs. The Foundation also reimburses the Missouri State Medical Association for expenses paid by the Association on behalf of the Foundation. There were no reimbursements made for such expenses for the year ended December 31, 1996 and 1995.

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MSMA Physicians' Health Foundation Financial Statements

REPORT OF
MISSOURI STATE MEDICAL ASSOCIATION PHYSICIANS' HEALTH FOUNDATION

December 31, 1996
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Association
Physicians' Health Foundation:

We have audited the accompanying Statements of Financial Position of Missouri State Medical Association Physicians' Health Foundation as of December 31, 1996 and 1995, and the related Statements of Activities and Changes in Net Assets and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association Physicians' Health Foundation as of December 31, 1996 and 1995, and the results of their operations for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 23, 1997

STATMENT OF FINANCIAL POSITION
December 31, 1996 and 1995

	1996	1995
ASSETS		
CURRENT ASSETS		
Cash	$ 3,314	$ 6,659
Accounts Receivable	11,210	6,905
Prepaid Expenses	-	840
Total Current Assets	14,524	14,404
PROPERTY AND EQUIPMENT		
Office Furniture and Equipment	12,764	6,339
LESS: Accumulated Depreciation	6,755	4,005
Total Property and Equipment	6,009	2,334
TOTAL ASSETS	20,533	16,738
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable (Note 3)	$ 2,378	$ -
Total Current Liabilities	2,378	-
TOTAL LIABILITIES	2,378	-
NET ASSETS		
Unrestricted	$18,155	$16,738
TOTAL NET ASSETS	$18,155	$16,738
TOTAL LIABILITIES AND NET ASSETS	$20,533	$16,738

STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
For the Years Ended December 31, 1996 and 1995

	1996	1995
REVENUES (Note 2)		
Contributions, Cash	$ 94,592	$ 91,211
Contributions, In-kind (MSMA)	30,570	30,723
Service Fees	81,020	62,085
Total Revenues	206,182	184,019
EXPENSES		
Professional Services	123,581	120,700
Office Supplies	10,546	5,127
Travel Expenses	13,806	9,797
Telephone	8,238	6,995
Office Rent	3,360	3,360
Contracts Expense	38,821	24,960
Dues and Subscriptions	0	150
Education and Training	2,982	847
Miscellaneous	225	261
Bank Service Charge	456	472
Depreciation	2,750	1,268
Bad Debt Expense	0	595
Total Expenses	204,765	174,532
INCREASE IN UNRESTRICTED NET ASSETS	1,417	9,487
NET ASSETS, BEGINNING	16,738	7,251
NET ASSETS, ENDING	$ 18,155	$ 16,738

The Notes to Financial Statements are an integral part of these Statements.

STATEMENT OF CASH FLOWS
INDIRECT METHOD
For the Years Ended December, 1996 and 1995

	1996	1995
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in Unrestricted Net Assets	$ 1,417	$ 9,487
Adjustments to reconcile increase in unrestricted Net Assets		
Depreciation	2,750	1,268
Increase in Accounts Receivable	(4,305)	(4,555)
Decrease in Prepaid Expenses	840	
Increase in Accounts Payable	2,378	-
NET CASH PROVIDED BY OPERATING ACTIVITIES	3,080	6,200
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Equipment	(6,425)	-
NET CASH PROVIDED BY INVESTING ACTIVITIES	(6,425)	-
NET INCREASE IN CASH	(3,345)	6,200
CASH, BEGINNING OF YEAR	6,659	459
CASH, END OF YEAR	$ 3,314	$ 6,659

NOTES TO FINANCIAL STATEMENTS
December 31, 1996 and 1995

Note 1. Summary of Significant Accounting Policies

Organization:

Missouri State Medical Association Physicians' Health Foundation was incorporated as a not-for-profit corporation under the laws of the State of Missouri on March 26, 1990.

The purpose of the Foundation is to support and promote quality professional health care through the sponsoring, supporting, initiating, funding, and establishing of the rehabilitation of chemically-dependent or mentally-impaired physicians.

The Foundation is a supporting organization under Internal Revenue Code Section 509 (a)(3). As such, the Foundation has common officers with the Missouri State Medical Association, a Section 501 (c)(6) organization. In addition, the six officers and directors of the Foundation are also directors and members of the Executive Committee of the Missouri State Medical Association.

Basis of Accounting:

The Financial Statements of Missouri State Medical Association Physicians' Health Foundation are prepared on the Accrual Basis of Accounting.

Financial Statement Presentation:

In 1996, Missouri State Medical Association Physicians' Health Foundation adopted Statement of Financial Accounting Standards (SFAS) No. 117. "Financial Statements of Not-For-Profit Organizations." Under SFAS No. 117, Missouri State Medical Association Physicians' Health Foundation is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Missouri State Medical Association Physicians' Health Foundation also adopted SFAS No. 116, "Accounting for Contributions Received and Contributions Made" in 1996. In accordance with SFAS No. 116 contributions received are recorded as unrestricted, temporarily restricted, or permanently restricted support depending on the existence and/or nature of any donor restrictions. The adoption of SFAS No. 116 had no effect on net assets or the change in net assets as of or for the year ended June 30, 1996. In addition, Missouri State Medical Association Physicians' Health Foundation has not received any contributions with donor-imposed restrictions that would result in temporarily or permanently restricted net assets.

Accounts Receivable:

Program service revenues are recognized when billed to participants and charged to accounts receivable. Accounts receivable are stated at face with no allowance for doubtful accounts as all probable uncollectible accounts have been written off or considered immaterial.

Property and Equipment:

Property and equipment are carried at cost on a straight-line basis over the estimated useful lives of the related assets.

Income Taxes:

The Foundation is qualified as a tax-exempt organization under Internal Revenue Code Section 501 (c)(3) and is not generally subject to Federal or State Income Tax.

Note 2. Revenues

The Foundation receives contributions from hospitals, physician groups, insurance companies, and interested individuals. Additionally, the Missouri State Medical Association underwrites a significant portion of operating expenses. Fees are also charged, in a nominal amount, to service recipients.

Note 3. Related Party Transactions

The Missouri State Medical Association (MSMA) provides significant support to the Foundation. MSMA had accounts payable for Foundation related expenses in the amount of $1,678 at December 31, 1996.

MSMA-HEF Financial Statements

REPORT OF MISSOURI STATE MEDICAL ASSOCIATION HEALTH EDUCATION FOUNDATION

December 31, 1996
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Association
Health Education Foundation:

We have audited the accompanying Statement of Financial Position of Missouri State Medical Association Health Education Foundation as of December 31, 1996 and 1995, and the related Statement of Activities and Changes in Net Assets, and the Statement of Cash Flows for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association Health Education Foundation as of December 31, 1996 and 1995, and the results of their operations for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 23, 1997

STATEMENT OF FINANCIAL POSITION
December 31, 1996 and 1995

	1996	1995
ASSETS		
CURRENT ASSETS		
Cash	$ 8	$ 929
Total Current Assets	8	929
TOTAL ASSETS	8	929
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable	42	6,651
Total Current Liabilities		
TOTAL LIABILITIES	42	6,651
UNRESTRICTED NET ASSETS	(34)	(5,722)
TOTAL LIABILITIES AND NET ASSETS	$ 8	$ 929

The Notes to Financial Statements are an integral part of these Statements.

STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
For the Years Ended December 31, 1996 and 1995

	1996	1995
REVENUES (Note 2)		
Contributions, Cash (MSMA)	4,000	20,000
Contributions, Cash (Other)	775	1,358
Contributions, In Kind (MSMA)	73,131	167,870
Total Revenues	77,906	189,228
EXPENSES		
Salaries and Wages	5,292	20,585
Payroll Taxes	404	1,569
Production Expenses	61,728	162,497
Professional Fees	3,059	3,669
Office Supplies	930	2,578
Travel and Meeting Expenses	294	4,447
Telephone	223	444
Advertising	0	885
Miscellaneous	288	0
Total Expenses	72,218	196,674
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	5,688	(7,446)
NET ASSETS, BEGINNING	(5,722)	1,724
NET ASSETS, ENDING	$(34)	$(5,722)

STATEMENT OF CASH FLOWS
INDIRECT METHOD
For the Years Ended December 31, 1996 and 1995

	1996	1995
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Net Assets	$ 5,688	$ (7,446)
Adjustment to reconcile Change in Net Assets to Net Cash Provided by Operating Activities		
Increase (Decrease) in Accounts Payable	(6,609)	6,651
Total Adjustments to reconcile Change in Net Assets to Net Cash	(6,609)	6,651
Net Cash Provided by Operating Activities	(921)	(795)
CASH AND CASH EQUIVALENTS, BEGINNING	929	1,724
CASH AND CASH EQUIVALENTS, ENDING	$ 8	$ 929

NOTES TO FINANCIAL STATEMENTS
December 31, 1996 and 1995

Note 1. Summary of Significant Accounting Policies

Organization:

Missouri State Medical Association Health Education Foundation was incorporated as a not-for-profit corporation under the laws of the State of Missouri on July 25, 1994.

The purpose of the Foundation is to produce thirty (30) minute video tapes to be televised throughout the State of Missouri to educate the general public about health issues.

The Foundation is a supporting organization under Internal Revenue Code Section 509 (a)(3). As such, the Foundation has common officers with the Missouri State Medical Association, a Section 501 (c)(6) organization. In addition, the six officers and directors of the Foundation are also directors and members of the Executive Committee of the Missouri State Medical Association.

Basis of Accounting:

The Financial Statements of Missouri State Medical Association Health Education Foundation are prepared on the Accrual Basis of Accounting.

Income Taxes:

The Foundation is qualified as a tax-exempt organization under Internal Revenue Code Section 501 (c)(3) and is not generally subject to Federal or State Income Tax.

Financial Statement Presentation:

In 1996, Missouri State Medical Association Health Education Foundation adopted Statement of Financial Accounting Standards (SFAS) No. 117 "Financial Statements of Not-For-Profit Organizations." Under SFAS No. 117, Missouri State Medical Association Health Education Foundation is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Missouri State Medical Association Health Education Foundation also adopted SFAS No. 116, "Accounting for Contributions Received and Contributions Made" in 1996. In accordance with SFAS No. 116, contributions received are recorded as unrestricted, temporarily restricted, or permanently restricted support depending on the existence and/or nature of any donor restrictions. The adoption of SFAS No. 116 had no effect on net assets or the change in net assets as of or for the year ended December 31, 1996. In addition, Missouri State Medical Association Health Education Foundation has not received any contributions with donor-imposed restrictions that would result in temporarily or permanently restricted net assets.

Note 2. Revenues

The Foundation receives contributions from hospitals, physician groups, insurance companies, and interested individuals. Additionally, the Missouri State Medical Association underwrites a significant portion of the operating expenses.

Note 3. Discontinued Operations

The Executive Committee of the Missouri State Medical Association Health Education Foundation voted to discontinue the production of educational video tapes effective February 29, 1996.

MSMI, Incorporated Financial Statements

REPORT OF
MSMI, INCORPORATED
December 31, 1996
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
MSMI, Incorporated:

We have audited the accompanying Balance Sheets of MSMI, Incorporated as of December 31, 1996 and 1995, and the related Statements of Income, Retained Earnings and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of MSMI, Incorporated as of December 31, 1996 and 1995, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 23, 1997

BALANCE SHEETS
December 31, 1996 and 1995

	1996	1995
ASSETS		
CURRENT ASSETS		
Cash	$ 23,085	$ 22,288
Total Current Assets	23,085	22,288
INVESTMENTS - COMMON STOCK	15,000	15,000
TOTAL ASSETS	$ 38,085	$ 37,288
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable (Note 3)	$ 20,000	$ 2,000
Total Current Liabilities	20,000	2,000
STOCKHOLDERS' EQUITY		
Common Stock, $10 par value: 3,000 shares authorized; 200 shares issued and outstanding	2,000	2,000
Related Earnings	16,085	33,288
Total Stockholders' Equity	18,085	35,288
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 38,085	$ 37,288

STATEMENTS OF INCOME
For the Years Ended December 31, 1996 and 1995

	1996	1995
INCOME		
Tour Commissions	$3,519	$4,264
Interest Income	626	557
Tour Commissions	120	0
Total Income	4,265	4,821
EXPENSES		
Bank Service Charge	47	48
Office Service (Note 3)	20,000	2,000
Professional Fees	1,376	1,117
Postage	0	32
Miscellaneous	45	0
Taxes, other	0	151
Total Expenses	21,468	3,348
NET INCOME (LOSS) BEFORE TAXES	(17,203)	1,473
Provision for Income Taxes	0	0
NET INCOME (LOSS)	$(17,203)	$ 1,473

The Notes to Financial Statements are an integral part of these statements.

STATEMENTS OF RETAINED EARNINGS
For the Years Ended December 31, 1996 and 1995

	1996	1995
BALANCE, BEGINNING	$33,288	$31,815
Net Income (Loss)	(17,203)	1,473
BALANCE, ENDING	$16,085	$33,288

STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1996 and 1995

	1996	1995
CASH FLOWS OPERATING ACTIVITIES		
Operations:		
Net Income or (Loss)	$(17,203)	$ 1,473
Increase in Accounts Payable	18,000	0
Increase in Cash	797	1,473
CASH, BEGINNING OF YEAR	22,288	20,815
CASH, ENDING OF YEAR	$ 23,085	$ 22,288

NOTES TO FINANCIAL STATEMENTS
December 31, 1996 and 1995

Note 1. Summary of Significant Accounting Policies

Organization:

MSMI, Incorporated was incorporated on December 11, 1974, under the laws of the State of Missouri. From inception to present, MSMI, Incorporated was, and continues to be, a wholly-owned subsidiary of the Missouri State Medical Association, a not-for-profit corporation under Internal Revenue Service Code Section 501 (C)(6).

The Company receives commissions on tours sold by a travel agency to members of the Missouri State Medical Association. These commissions represent substantially all of the Company's income.

Basis of Accounting:

The Financial Statements of the MSMI, Incorporated are prepared on the Accrual Basis of Accounting.

Note 2. Investments

The Company acquired 4,000 shares of Class A common stock of MOMED Holding Company (Originally Missouri Medical Insurance Company) on November 21, 1980.

During December, 1996, MOMED Holding Company merged with MAIC Holdings, Inc. MAIC Holdings is headquartered in Birmingham, Alabama where it began operations in April, 1977 as Mutual Assurance, a mutual insurer operating solely in the state of Alabama. The company converted to a public stock insurer in September, 1991, and formed its holding company, MAIC Holdings, Inc. in August, 1995. The Company's stock now trades on the New York Stock Exchange under the symbol MAI.

As a result of the merger, at December 31, 1996, MSMI owns 9,348 shares of MAIC Holdings, Inc. On December 31, 1996, MAIC Holdings, Inc., closed on the New York Stock Exchange at 31 13/16, thus assigning the market value of $297,383.

Investements in marketable equity securities are carried at the lower of aggregate cost or market at fiscal year end. Original cost was $15,000. Market value of the shares at December 31, 1995 was $28,000. The substantial increase is primarily the result of a 2 for 1 stock split in MOMED Holding Company during the year and the conversion to a public stock rather than an essentially closed corporation which had earlier resulted in limited salability.

Note 3. Related Party Transactions

Missouri State Medical Association is the parent corporation of MSMI, Incorporated. The Association is organized as a not-for-profit corporation under the laws of the State of Missouri, and owns all of the 200 shares of capital stock issued and outstanding of the Company. All office services of the Company are provided or performed by the Association with a fee assessed for such services. For the years ended December 31, 1996 and 1995, this fee was $20,000 and $2,000 which was due to the Association on December 31, 1996 and 1995, respectively.

MSMS, Incorporated Financial Statements

REPORT OF
MISSOURI STATE MEDICAL SERVICES, INC.
December 31, 1996
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Services, Inc.:

We have audited the accompanying Balance Sheets of Missouri State Medical Services, Inc., as of December 31, 1996 and 1995, and the related Statements of Income, Retained Earnings and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Services, Inc., as of December 31, 1996 and 1995, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 23, 1997

BALANCE SHEETS
December 31, 1996 and 1995

	1996	1995
ASSETS		
CURRENT ASSETS		
Cash	$ 7,529	$ 40,371
Accounts Receivable, net of Allowance for Doubtful Accounts (Note 1)	28,840	14,746
Employee Advances	500	500
Total Current Assets	36,869	55,617
PROPERTY AND EQUIPMENT (Note 1)	3,460	3,460
LESS: Accumulated Depreciation	(1,730)	(1,038)
Total Property and Equipment	1,730	2,422
TOTAL ASSETS	$ 38,599	$ 58,039
LIABILITIES AND STOCKHODLER'S EQUITY		
CURRENT LIABILITIES		
Notes Payable (Note 3)	$202,767	$ 185,630
Accounts Payable	26,743	2,735
Accrued Expenses	2,600	2,600
Interest Payable	19,230	16,702
Total Current Liabilities	251,340	207,667
STOCKHOLDER'S EQUITY		
Common Stock, $1 par value; 30,000 shares authorized; 30,000 shares issued and outstanding	30,000	30,000
Retained Earnings	(242,741)	(179,628)
Total Stockholder's Equity	(212,741)	(149,628)
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 38,599	$ 58,039

STATEMENTS OF INCOME
For the Years Ended December 31, 1996 and 1995

	1996	1995
INCOME		
Consulting Fees (Note 1)	$134,750	$ 161,720
Seminar Fees	-	2,261
Recuiting Revenue	8,595	0
Interest Income	821	1,408
Miscellaneous	-	1,120
Total Income	144,166	166,509
EXPENSES		
Salaries	$ 94,596	$133,995
Administrative Fees (Note 3)	21,000	-
Meetings and Retreats	-	1,593
Travel and Entertainment	9,518	21,378
Rent	12,333	15,996
Telephone	5,507	10,165
Printing and Supplies	1,919	4,864
Contract and Professional Fees	11,268	4,817
Miscellaneous Expense	370	775
Provision for Bad Debts	30,847	-
Depreciation	692	813
Interest Expense	19,229	16,702
Total Expenses	207,279	221,098
NET INCOME (LOSS) BEFORE	(63,113)	(54,589)
Provision for Income Taxes	-	-
NET INCOME (LOSS)	$ (63,113)	$(54,589)

STATEMENTS OF RETAINED EARNINGS

For the Years Ended December 31, 1996 and 1995

	1996	1995
BALANCE, BEGINNING	$(179,628)	$ (125,039)
Net Income (Loss)	(63,113)	(54,589)
BALANCE, ENDING	$(242,741)	$(179,628)

STATEMENTS OF CASH FLOWS

For the Years Ended December 31, 1996 and 1995

	1996	1995
CASH FLOWS FROM OPERATING ACTIVITIES		
Operations:		
Net Income or (Loss)	$(63,113)	$ (54,589)
Adjustments to Reconcile Net Income (Loss) to Net Cash Provided (Used) by by Operating Activities:		
Depreciation	692	813
(Increase) Decrease in Accounts	(14,094)	9,991
Decrease in Employee Advances	-	1,000
Increase in Accounts Payable	24,008	2,735
Increase in Interest Payable	2,528	11,909
Net Cash Provided (Used) by Operating Activities	(49,979)	(28,141)
CASH FLOWS FROM INVESTING ACTIVITIES		
Sale of Property and Equipment	-	963
Net Cash Provided (Used) by Investing Activities	-	963
CASH FLOWS FROM FINANCING ACTIVITIES		
Proceeds from Short-term Debt	17,137	35,133
Proceeds from Issuance of Common Stock	-	-
Net Cash Provided (Used) by Financing Activities	17,137	35,133
Net Increase (Decrease) in Cash	(32,842)	7,955
CASH, BEGINNING OF YEAR	40,371	32,416
CASH, END OF YEAR	$ 7,529	$ 40,371

NOTES TO FINANCIAL STATEMENTS

December 31, 1996 and 1995

Note 1. Summary of Significant Accounting Policies

Organization:

Missouri State Medical Services, Inc. was incorporated on February 2, 1994, under the laws of the State of Missouri. From inception to present, Missouri State Medical Services, Inc., was, and continues to be, a wholly-owned subsidiary of the Missouri State Medical Association, a not-for-profit corporation under Internal Revenue Service Code Section 501 (c)(6).

The Company receives consulting fees for managerial and advisory services to physician practices and managed care organizations. These fees represent substantially all of the Company's income. Additionally, the Company receives fees for presentations of seminars.

Basis of Accounting:

The Financial Statements of the Missouri State Medical Services, Inc., are prepared on the Accrual Basis of Accounting.

Accounts Receivable:

Consulting fees are recorded as revenue and charged to accounts receivable after initial services have been provided and the clients have agreed to proceed with the engagement. Some services are provided initially that may not be charged to the client if no further engagement is agreed upon. Accounts receivable are stated at face amount net of an allowance for doubtful accounts. The allowance for doubtful accounts is management's estimate of uncollectable accounts as of the balance sheet date, and actual results may vary from these estimates. The allowance for doubtful accounts was $30,847 and $-0- at December 31, 1996 and 1995, respectively.

Property and Equipment:

Property and equipment are carried at cost. Depreciation is recorded on a straight-line basis over the estimated useful lives of the related assets.

Income Taxes:

The Company has an operating loss carry forward of $243,000 that may be offset against future taxable income. If not used, the carry forward will expire in the years 2009 through 2011.

Note 2. Cash Held in Trust for Others

At December 31, 1994, the Company held in its operating account deposits totaling $10,500. These funds were received from various physicians or physician groups in the St. Louis area for the purpose of establishing a future Management Services Organization (MSO), which would be separate and autonomous from the Company. These funds were being held in trust by the Company and were disbursed or returned during 1995. The Company was not liable for interest payments on the funds.

Note 3. Related Party Transactions

Missouri State Medical Association is the parent corporation of Missouri State Medical Services, Inc. The Association is organized as a not-for-profit corporation under the laws of the State of Missouri, and owns all of the 30,000 shares of capital stock authorized, issued and outstanding of the Company. The Association charges the Company for administrative fees and other expenses incurred by the Association on behalf of the Company. The Company owed the Assocation $21,000 for administrative fees at December 31, 1996.

The Company has a demand note payable to Missouri State Medical Association in the amount of $202,767 and $185,630 at December 31, 1996 and 1995 respectively, with interest at the rate of 9.50% in 1996 and 1995. The interest rate adjusts annually on January 1st to the Chase Manhattan prime rate plus 1%.

Missouri State Medical Association

MoMed Net

http://www.msma.org

Unlimited Access
MSMA members may subscribe to receive full and ***UNLIMITED*** access to the Internet for $17.50 monthly. Billed monthly automatically on a Visa or MasterCard credit card account, you can surf the Internet for as long as you wish for one low price!

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MSMA will provide you with **Sprint Internet Passport**, an Internet Web Browser software that utilizes Netscape Navigator. Sprint Internet Passport automatically dials a local telephone number (no long distance charges!) and connects you to our World Wide Web Home Page at **http:/www.msma.org**. Our Home Page is your 'one-stop-shop' for medical information! You can be instantly be connected to MSMA, other medical sites or use search tools to take you anywhere on the Internet.

Unsurpassed Accessibility & Fast Connections
The Sprint Internet Passport software has been engineered to assure you of a 95% Internet connection rate, with modems up to 28.8 Kbps, so you get the information you need, fast!

Computer Equipment Requirements
Minimum requirements to be connected to **MoMed Net**: a Windows operating system, a 14.4 Modem or higher, a 386 or higher, and at least 8 megs of RAM.

Password Protection
Security and password protection keep information at the MSMA Web site preserved for members only.

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Through **MoMed Net**, you will have global e-mail service, (one e-mail address per account), connecting you to thousands of Association members and physicians all over the world!

Training Seminars and Technical Assistance
Don't know how to use the Internet?
MSMA will be presenting Internet workshops called "Physicians Accessing the Internet" to show you how to take advantage of the Internet's resources.
Need technical assistance? Sprint will be providing toll-free technical support, 24-hours-a-day, seven-days-a-week.

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MoMed Net is now available in these four locations: St. Louis, Kansas City, Springfield, and Jefferson City. But if you are not in **MoMed Net's** calling areas, we can still help you! MSMA offers access to our home page through your local Internet Service Provider.

How Do I Sign Up?
Fill out the **MoMed Net** application and fax it to MSMA at 573-636-8552. MSMA will verify that you are a member in good standing. If you are within the **MoMed Net** calling area, MSMA will send you the software and program installation instructions.
If you are not within the **MoMed Net** calling area, MSMA will give a user identification and password. Either way, you'll be on your way to surfing the Information Superhighway!

Questions? Contact the MSMA at 573-636-5151.

fm297

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Missouri State Medical Association

MoMed Net

Internet Service Applicatio

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Name ____________________

Billing Address ____________________

City/State/Zip ____________________

Tel# ____________________ Fax# ____________________

Signature ____________________ Date ____________________

E-Mail Address (if applicable) ____________________

SYSTEM REQUIREMENTS

To ensure the highest quality service, your hardware requirements for MSMA Internet Service need to be:

- ✓ Operating Systems
  - Windows 95
  - Windows 3.1
  - Windows NT
- ✓ 14.4 Modem or higher
- ✓ 386 or higher
- ✓ 8 megs of RAM or higher

If you do not meet these minimum requirements, we request that you upgrade to ensure proper Internet connectivity and operations.

TYPE OF OPERATING SYSTEM

_____ Windows 3.1 _____ Windows 95
_____ Windows NT
_____ Other: ____________________

Modem Brand ____________________ Speed __________

TYPE OF COMPUTER

_____ 386 _____ Pentium
_____ 486 _____ Other

Please check the MSMA information files you would like to see on-line.

- ○ *Progress Notes*
- ○ *Missouri Medicine*
- ○ Legislative
- ○ Health Care Finance
- ○ Continuing medical education listings
- ○ On-line continuing medical education
- ○ Medical-legal
- ○ Alliance news
- ○ Membership
- ○ Council and committee reports
- ○ County/metropolitan society news
- ○ Medical specialty news
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- ○ Other ____________________

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Software Distribution Date: ____________________ Membership Confirmation Date: ____________________

NOTE: *Users must use ID and Password to enter the confidential MSMA section.*

Sprint Healthcare Systems, Inc. Spri

Membership Notes

The **Greene County Medical Society** recently installed **James B. Wolfe, MD,** as President and **Catherine Schane, MD**, as President-Elect.

The 1997 officers for the **St. Louis Metropolitan Medical Society** are **Charles C. Norland, MD**, President; **K. Lynne Moritz, MD**, President-Elect; **John M. Laird, MD**, Vice President; and **Richard J. Gimpelson, MD**, Secretary.

The 1997 officers of the **Cape Girardeau County Area Medical Society** are **Gordon L. Haycraft, MD,** President; **Richard A. Martin, MD,** Vice President; **A. Basit Chaudharl, MD,** Secretary; **R. Dan Bieser, DO,** Treasurer.

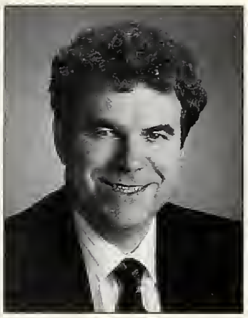
Felix N. Sabates, MD, was recently re-elected President of the **Eye Foundation of Kansas City**. **Larry W. Piebenga, MD,** and **Nelson R. Sabates, MD**, are continuing Board of Trustees members for the Foundation.

Marsha McBride, MD, a resident in obstetrics and gynecology at St. John's Mercy Medical Center, was honored by the American Medical Association during its Resident Physician Section December Interim Meeting in Atlanta.

Dr. McBride was one of 40 resident physicians from around the United States who were honored as part of the AMA/Glaxo Wellcome Leadership Award Program.

The AMA established the program in 1988 to honor resident physicians who display leadership and a strong commitment to the health of their patients and the community as a whole through community service outreach.

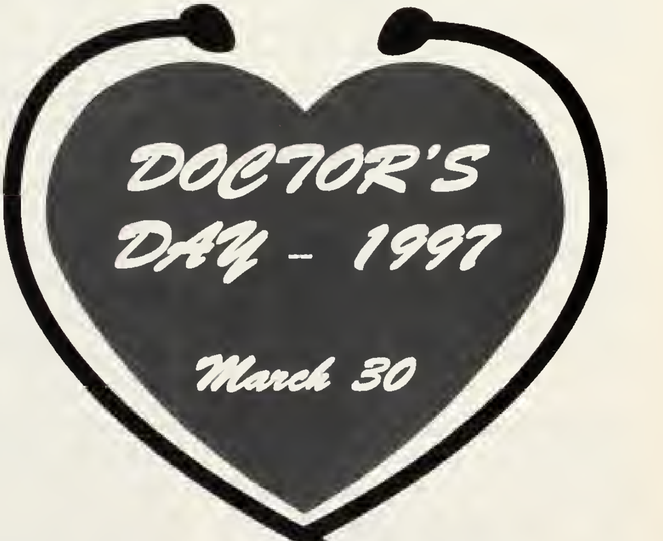
In 1992, with the assistance of fellow medical students from St. Louis University, Dr. McBride helped found the Health Resource Center. The center is a free medical clinic for people in need in St. Louis. The project started with the support of the Geriatric Interest Group for Students and expanded to include members of AMAs Medical Student Section, American Medical Students Association, and BREM Catholic Social Ministries. Dr. McBride still plays an active role in the Health Resource Center as it continues to grow to serve community needs.



Pat Harr, MD, practicing Maryville physician, was inaugurated as President of the American Academy of Family Practitioners on October 5, 1996 in New Orleans. He will lead the AAFP in its 50th year of existence.

Dr. Harr has served as the Missouri Academy president, board chair, and national delegate to the AAFP Congress of Delegates, and has held numerous committee posts with the MAFP. In addition, he has served as Vice President with the Missouri State Medical Association.

Dr. Harr is affiliated with St.Francis Hospital in Maryville. He received his degrees from Northwest Missouri State University, Maryville, and the University of Missouri, Columbia.



In Memoriam

James A. Direnna, Sr., DO, 83, Gladstone, died December 27, 1996. He received his doctor of osteopathy degree from the Kansas City College of Osteopathic Medicine. He held certifications and fellowships with the American College of Osteopathic Surgeons and the American College of General Practicioners in Osteopathic Medicine and Surgery. He served on staff at the University of Health Sciences as professor of surgery, faculty advisor, chairman of the general surgical division, chief of the department of surgery, and chief of staff. He was a director for the National Jewish Hospital and Research Center, Denver Co. and was past director of Kansas City General Hospital and Medical Center. He was a member of the Missouri State Medical Association.

Frank R. Daley, MD, 78, Hamilton, died December 31, 1996. He attended the University of MO-Columbia and Washington University, St. Louis. He practiced medicine in Hamilton from 1946 until his retirement in 1988. Dr. Daley was a member of the Missouri State Medical Association.

Ralph Bohnsack, MD, 83, Fort Worth, TX, formerly of Brookfield, died January 2, 1997. He practiced medicine in Brookfield from 1946 until 1980. Dr. Bohnsack was a member of the Missouri State Medical Association.

Katherine Crawford, MD, 77, Carrollton, died January 13, 1997. She earned her bachelor's degree from Michigan State University in East Lansing and her medical degree from the Women's Medical College of Pennsylvania. She completed her residency at the old City Hospital. She was on staff at Deaconess Hospital. Dr. Crawford was on the faculty at Washington University Medical School and was medical director for 20 years at Grace Hill Neighborhood Health Center. She maintained a private practice in St. Louis for 40 years. After her retirement in 1983, she moved to Carollton. She was a member of the Missouri State Medical Association.

August W. Geise, MD, 66, Creve Coeur, died January 14, 1997. He received his bachelor's and medical degrees from Washington University. Dr. Geise was in private practice for 30 years. He was chairman of the division of neurosurgery at St. Luke's when he retired in 1995. Since 1965, he was on staff at St. Luke's Jewish Hospital, Missouri Baptist Hospital, and the Shriners Hospital for Children. From 1964 to 1986, he was a clinical assistant professor at the University of MO-Columbia School of Medicine. Dr. Giese was a past president of the Neurosurgical Society of America, the St. Louis Medical Society, and the State Board of Registration for the Healing Arts. He was also past president of the Washington University Medical Alumni Association. He was a member of the Missouri State Medical Association.

Wilfred W. Wooldridge, MD, 79, Springfield, died January 18, 1997. He was a graduate of Drury College and Washington University Medical School in St. Louis. Dr. Wooldridge was a practicing dermatologist in Springfield for 38 years before retiring in 1987. In addition, he was an Associate Professor Emeritus at the University of MO-Columbia School of Medicine and taught specialty aspects of dermatology at the Schools of Medicine at the University of Oklahoma, the University of Arkansas, and Washington University in St. Louis. Dr. Wooldridge was a long-time editor for the Greene County Medical Association and Missouri State Medical Association Journals. He also served as Vice President for the Missouri State Medical Association.

August Piper, MD, 83, St. Louis, died January 19, 1997. He received his undergraduate degree from Lincoln University in Jefferson City. He earned his master's degree from the University of Minnesota and his medical degree from Meharry Medical College, Nashville, Tn. Dr. Piper maintained a private practice in St. Louis for more than 35 years and was affiliated with Cardinal Glennon Children's Hospital, the old St. Mary's Infirmary, People's Hospital, St. Louis University, and the St. Louis Health Department clinics. He also served as a school physician for the St. Louis Public Schools. Dr. Piper retired in 1988.

Walter Gunn, MD, 88, St. Louis, died January 22, 1997. He received his undergraduate and medical degrees from St. Louis University. Dr. Gunn was in private practice for nearly 65 years. He was on staff at St. Anthony's Medical Center in south St. Louis County and Alexian Brothers Hospital. Dr. Gunn was a Past President for the Missouri State Medical Association. He retired in 1996.

Walter Moore, MD, 91, St. Charles, died January 22, 1997. He received his medical degree from St. Louis University and completed his post-graduate study in neuropsychiatry at Washington University and his residency at St. Louis State Hospital. He was hired as assistant superintendent at St. Louis State Hospital in 1940 and served as superintendent from 1942 to 1945. He was a member of the Missouri State Medical Association.

Harold A. Budke, MD, 82, Kasas City, died January 25, 1997. He received his medical degree from Washington University School of Medicine in St. Louis and practiced as a family physician in Kansas City from 1946 until his retirement in 1981. He was a member of the Missouri State Medical Association.

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Only restaurant in Missouri ever to receive the prestigious AAA Five Diamond Award.

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Terri Skalitzky, MD
5600 Bannister Rd.
Kansas City, MO 64137
Univ of MO-Kansas City; 1992

Boone

Samuel Collins, MD
17 Yorkshire Dr.
Columbia, MO 65203
East Carolina Univ; 1992

Richard Davis, Jr., MD
3309 Oakside Ct.
Columbia, MO 65203
Columbus Univ Col; 1974

Dayna Early, MD
115 Business Loop 70 W
Columbia, MO 65203
Univ of MO-Columbia; 1990

Eldin Karaikovic, MD
2913 Blue Grass Ct.
Columbia, MO 65201
Univ of Sarajevo; 1983

Clay-Platte

Angela Olomon, DO
5700 N. Broadway
Gladstone, MO 64118
Univ Health Sci-Kansas City; 1986

Johnson

Mark Hechler, DO
515 Burkarth Rd.
Warrensburg, MO 64093
Kirksville Col Osteo Med; 1991

Lake of the Ozarks

Kevin Byrne, DO
54 Hospital Drive
Osage Beach, MO 65065
Univ Health Sci-Kansas City; 1989

Metro Med of Greater KC

Kimberly Davis, MD
17012 E. 44th St. SO
Independence, MO 64055
Univ of Nebraska; 1988

John Doane, MD
4801 Cliff Ave., Ste 100
Independence, MO 64055
Univ of Kansas; 1990

Residents-Kansas City

Ahmad Batrash, MD
7353 Brittany #206
Merriam, KS 66203
Damascus Univ; 1993

Marie Philipneri, MD
4314 Northern Ave. #2523
Kansas City, MO 64133
Univ of Guyana; 1994

Northeast

Cynthia Davis, MD
711 Grand
Hannibal, MO 63401
Univ of Florida; 1992

St. Charles-Lincoln

John Williams, Jr., MD
2 Westbury Dr.
St. Charles, MO 63301
Cornell Univ; 1989

St. Louis Metro

Susan Luedke, MD
6150 Oakland Ave. Ste. 180
St. Louis, MO 63139
Univ of Rochester; 1992

Residents-St. Louis

Mary Koly, MD
1696 Somerset Shire
Florissant, MO 63031
Univ of MO-Kansas City; 1995

Carol Smith, MD
6233 Northwood Ave. 1-E
St. Louis, MO 63105
Jefferson Med Col; 1995

Students-Univ of MO-Kansas City

Robert Chang
Shannon Forseter
Christopher Longnecker
Christopher Nelson, Jr.
Wylan Peterson
Casey Prough
Gordon Rainey
Michael Williams
Kishan Yalavarthi

CME Calendar

March

20 - *Satellite Teleconference*: **Update on Viral STDs: Genital Herpes and Human Papillomavirus.** 2 credit hours. Call Washington University School of Medicine 314-747-0294.

21 - *St. Louis*: **Anatomy for Emergency Physicians.** 4 credit hours. Call 314-535-4000.

21 & 22 - *St. Louis*: **Integrated Care of the Thoracic Surgery Patient. A Seminar for Allied Health Professionals.** Call Washington University School of Medicine 314-362-6891.

22 - *St. Louis*: **New Approaches to the Management of HIV Disease: Update from the 4th Conference on Retroviruses and Opportunistic Infections.** 4 credit hours. Call Susan Wightman 314-362-2418.

27 thru 29 - *St. Louis*: **Surgical Approaches to the Skull Base.** 22 credit hours. Call 314-535-4000.

March thru May - *St. Louis*: **Internal Medicine Review.** (Monday evening) Call Washington University School of Medicine 314-362-6891.

April

4 - *St. Louis*: **Leonard Berg Symposium on Alzheimer's Disease.** Call Washington University School of Medicine 314-362-6891.

4 thru 6 - *St. Louis*: **Complete Foot Care Course.** Call Cindy Slisz at the American Orthopaedic Foot and Ankle Society 1-800-235-4855.

4 & 5 - *S. Louis:* **Clinical Pulmonary Update.** 8 credit hours. Call Washington University School of Medicine 314-362-6891.

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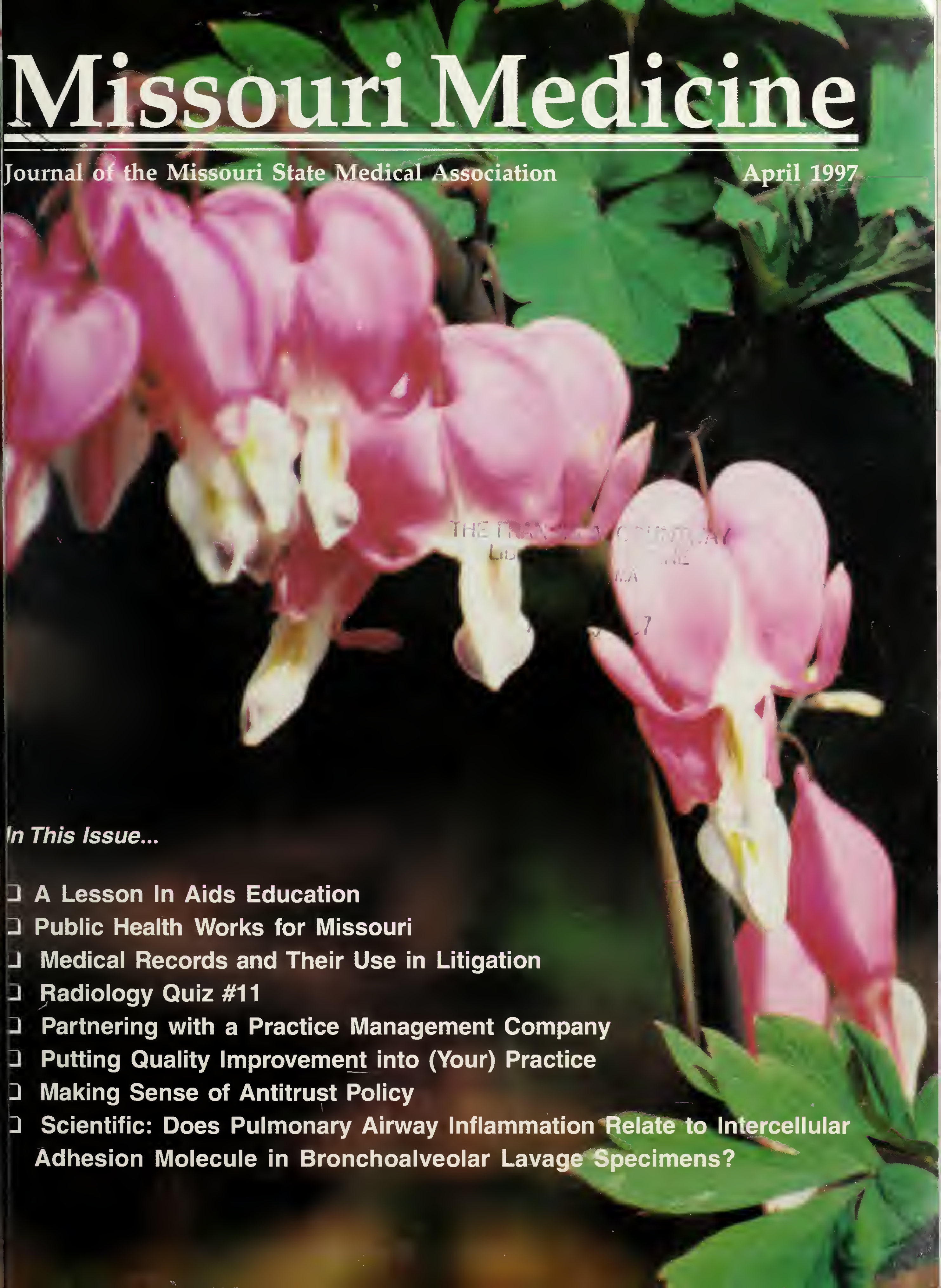

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"Farm Boy Admonitions"

J. Regan Thomas, MD, Editor

As we approach the new millennium, perhaps one of the most significant scientific accomplishments has been announced as we finish this century. Researchers have cloned an adult mammal sheep. This cloning of a complex mammal is a true scientific landmark. The feat brings with it tremendous ethical questions which no doubt will bring heated and prolonged discussion for years to come.

The project was reported in the journal *Nature* by a team from Roslin Institute of Edinburgh, Scotland. The researchers took unfertilized sheep eggs and removed the cell nucleus, thus removing its DNA genetic code. Using udder tissue cells from an adult ewe, they fused them with the manipulated egg cells, developing new cells with a complete set of chromosomes. These eggs now contained a functioning nucleus and developed into embryos as though they had been fertilized. The cloned embryos were then placed into ewes to develop. Photos of the first clone of an adult mammal, a seven-month-old sheep named Dolly, were released to the lay press with great fanfare. Many experts were shocked to hear the news. Although some clone work had been accomplished in frog eggs and simpler organisms, many did not think it would be possible in a complex mammalian system. Indeed the process, as reported, was at this stage inefficient. Of the 277 fused eggs initially, only one developed into a growing embryo clone. But now, reportedly nine cloned sheep have been born. Each of them is an identical genetic copy of the parent which provided the cell. The clone's cells are entirely identical to the genetic makeup of its single "parent" rather than the 50:50 combination from normal fertilization of sperm and egg.

Question number one is, "Why?"

Question number one is, "Why?" Ethical concerns make the cliche "scientific search for knowledge" and "to see if it could be done" answers strained at best. I'm sure some answers will be aimed at agribusiness applications. Beef cattle, for example, could be cloned from cows with the most ideal protein vs. fat content and physical characteristics that would make them most marketable. Dairy cattle which produce the most milk or resist specific ailments could be cloned and highly productive herds produced without using the presently controversial hormonal manipulation. Cloning might produce greater egg producers in poultry or perhaps fryers with more desirable characteristics such as greater white meat. There are obviously those with greater sophistication on these issues than I, but it seems to me that biodiversity (rather than cloned sameness) produces a stronger disease resistant population. Pitting cloned selectivity vs. stronger, diverse genetic makeup is a question to be resolved in the face of the new genetic technical skill.

Another answer to the why question is likely to be related to the already burgeoning gene splicing industry. Perhaps cloning will make insertion of genes more efficient to reproduce. I am sure the biomedical and pharmaceutical scientists have already begun to think about developing a cloned cow, for example, that could make use of a spliced gene that could create a protein-bound substance (i.e. drug) that could be secreted in the milk. This walking, mooing, biopharmacy would be cloned into herds of useful animals. Apparently, there are about 700 biotechnical companies throughout the world right now working on this issue. As a former farm boy who has milked a few cows, I can't help but think there is a

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more efficient and economical manner to reach this end than to depend on a not so bright, 2,000 pound mammal that has to be fed and milked twice a day. These 700 companies are probably smarter than me so I'm willing to wait and see.

The most compelling question of course is the possibility of cloning humans. Most of the scientific world involved in the field are saying it would not be ethical, that it is amoral, and should not be done. The ethical considerations have been debated for some time. But now, the possibility is real and tangible in the form of a sheep named Dolly. There is now, for the first time, the technical ability to actually clone a human (sheep actually have more chromosomes than humans, so it may be that human cloning is even easier). Now the ethical question itself is real.

In a world where we haven't been able to resolve many of our present bioethical problems well, it doesn't seem prudent or wise to proceed with this one. Already, certain steps are being taken to block further movement. Apparently, funding for cloning research is being stopped in Great Britain. Here in the U.S., legislators are already offering legislation which would ban research in human cloning. It doesn't seem too long ago that in vitro fertilization seemed unlikely and sensationalized stories of "test tube" babies surprised and shocked the world. Recently, a couple conceived a daughter to specifically become a marrow donor for their other ill daughter. This raised many ethical and perhaps unresolved issues. Even situations as easily accomplished by today's technology as surrogate mothers or artificial insemination, sperm and egg banks, and frozen embryo maintenance have not been resolved by the ethical standards of many. Certainly, the legal and regulatory answers are far behind the science at this point.

Maybe the big question is actually, "Do we really want to go further?" It seems most of the world is not ready for additional challenges of this kind at this time. There are many questions and issues to resolve first. Perhaps the farm boy analogy works here too. When walking to the dairy barn, always proceed slowly and watch every step. MoMed

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1997-98 MSMA President

A.J. Campbell, MD
MSMA President

A.J. Campbell, MD, a Family Physician from Sedalia, will serve as President of the Missouri State Medical Association in 1997-98. He will be installed April 12, 1997, during MSMA's 139th Annual Convention in Kansas City.

Dr. Campbell was born in Sedalia in 1931. He earned his medical degree in 1956 from the University of Pennsylvania, Philadelphia, and completed his internship at the University of Michigan, Ann Arbor.

He is board certified by the American Board of Family Practice and is a Charter Fellow in the American Academy of Family Physicians. Dr. Campbell serves on the Legislative Committee for the Missouri Academy of Family Practice and on the Board of Directors for the Mid-Missouri Area Health Education Centers. Since 1957, he has been on the staff at Bothwell Regional Health Center in Sedalia.

1997 marks the 40th year Dr. Campbell has been a member of the Missouri State Medical Association. He has served as a MSMA Councilor since 1981. He was Chair of the Council in 1995-96 and Vice Chair of the Council in 1994-95.

Dr. Campbell has served as Secretary and President of the Pettis County Medical Society. He also served as a member of the Ethics Committee.

As a member of the American Medical Association, he has served on the Organized Medical Staff Section as a Bothwell Regional Health Center representative and Reference Committee Member.

In assuming his leadership position for the Association, Dr. Campbell outlines three main goals:

"First, building an organization which is relevant to the needs of physicians today is crucial if we are to make a meaningful contribution, retain existing members, and cultivate new memberships. Participation is the lifeblood of any healthy organization, and participation can grow only to the degree that we meet the needs of our membership. We need our members to be able to proudly describe the current benefits of MSMA membership. At the same time we should explore new ways in which the organization can grow to address the changing needs we all have in the uncertain arenas of managed care, as well as the needs unique to subgroups of physicians -- young, two-career couples, retiring physicians, physicians operating in managed care environments, to name only a few.

Secondly, helping physicians maintain quality medical care for their patients in a managed care environment is paramount. Physicians have previously managed the care of the patients based on what was most medically correct for the patient. Now, non-physicians are managing care many times with "bottom line" financial concerns taking precedence over what is truly best for an individual patient, or imposing treatment pathways and algorithms which fail to take into account the variability and vulnerability of people who may share the same diagnostic codes.

MSMA needs to help physicians resume their place in managed care by:

1. Developing a mature state wide Management Services Organization.

A.J. Campbell, MD

2. Expanding Missouri State Medical Services, Inc. to help physicians protect their patients and themselves in contracts and mergers, as well as other financial matters.

Finally, we need to promote camaraderie and collegiality among physicians. Who more than our fellow physicians understand the complexities, frustrations, family stresses, and the deep and abiding satisfaction associated with caring for others? We need to show our fellow physicians the respect and courtesy they, like we, need and deserve. Honest debate can be productive; turf battles and bickering detract from our own integrity and weaken the community and fellowship among physicians.

In order to accomplish these three goals, we must devise effective strategies. I plan to make this part of the discussion at the upcoming MSMA Long Range Planning Retreat. Please send me your suggestions and comments on these topics at MSMA, P.O. Box 1028, Jefferson City, MO 65102." MoMed

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Becky Moore
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Becky Moore

Becky Moore will be installed as the 1997-1998 President of the Missouri State Medical Association Alliance, April 12, 1997, during the 72nd MSMAA Annual Convention at the Westin Crown Center in Kansas City.

Becky, originally from Mississippi, attended Mississippi State University and graduated from the University of Mississippi School of Nursing in Jackson.

Becky and Thomas Moore, MD, were married in 1970. In 1982, they moved to Joplin where Tom is a practicing cardiologist. They have three daughters and one son, all of whom are in college or graduate school.

Currently, Becky is a Surgical Registered Nurse at St. John's Regional Medical Center in Joplin, an Associate with Prepaid Legal Services, Inc., and a Disciple Bible Study Leader.

Becky's involvement in the medical alliance began in 1970 in Jackson, Mississippi, where Tom was a medical student. In 1982, she joined the Jasper County Medical Alliance and has held the offices of President, Legislation Chair, and Health Chair.

As a member of the Missouri State Medical Association Alliance, Becky has held the offices of President-Elect, Legislative Vice President, AMA-ERF Vice President, MMPAC Chairman, and Courtesy Chairman.

Becky's theme for 1997-1998 is *Partners in Caring,* "Being the spouse of a physician is a privilege and a responsibility. Medical families are a lot different from other families," Becky said. "It takes a real partnership of sharing responsibility in raising a family of a physician."

Becky's goal is to increase caring in the community and she would like to share her good fortune. "I would like to share the privileges we have because of our good fortune of being married to a physician," Becky said. "We can give back to the community what has been given to us."

Some of Becky's plans for 1997-1998 include:

- A Leadership Conference is planned in Columbia on May 6, 1997, for county leaders. At the conference, the county leaders will be presented with ideas to implement in their counties.
- A Fall Conference is scheduled for October in Branson. Nina Brueckner, a motivational speaker, will discuss relationships. This program can be applied to county relationships or your personal relationships.
- On Saturday of the conference, a CME course, sponsored by St. John's Regional Medical Center in Joplin, is planned for physicians who join their spouses in Branson for the weekend.
- MSMAA Day at the Legislature, which was a huge success this year, is tentatively scheduled for March 3 and 4, 1998.
- The 73rd Annual Convention will be held April 15-19, 1998 at the Marriott Pavilion Hotel in St. Louis. MoMed

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A Lesson In Aids Education

Vasu Kakarlapudi, Medical Student, MSMA Vice-Councilor

It was the first day of my first internal medicine rotation at Truman Medical Center in Kansas City. I was excited and yet at the same time nervous because older students had joked with us about all the disgusting duties the junior students would be expected to perform. My senior partner and I were dealt the responsibility of admitting patients to our service for the day. The first patient we admitted was relatively easy; a sickle cell patient suffering from a faso-occlusive crisis. The second patient we admitted taught me more about patient care than I ever imagined a single patient could do. For the purpose of this article, I will refer to him as John.

Our resident called us and told us we had an AIDS patient with a chief complaint of diarrhea. There was a sense of frustration in his voice for it was 4:25 p.m. and we were to stop taking admissions at 4:30 p.m. As we were walking to the patient's room, I was a little nervous, for I had never seen a person with AIDS face to face. Now I would have to complete a physical exmination on such a patient.

> **The lesson I learned from this experience is to put aside personal prejudices and pre-conceptions in the name of quality patient care.**

John was 51-years-old and had end stage AIDS. Even though I was taught and had no doubt in my mind HIV was not transmitted by normal body contact, I was still hesitant to interview and examine John. My most vivid recollection is wearing three or four layers of latex gloves during the rectal exam. I had developed preconceptions about what AIDS patients were like without ever having seen one. John was friendly and cooperative but had a markedly abnormal mental status exam. Through further investigation of previous hospital records and conversations with family members, we discerned that mental status changes and global weakness were the primary reasons the patient came to the hospital. That night, I remember telling my friends and parents about this eye-opening experience.

Over the next week, I began to develop a professional relationship with John and his mother and brother who were with him nearly every time I visited his room. They were all so grateful of the treatment we were providing him. John and his mother even took the time to learn how to correctly spell and pronounce my first and last names. Gradually, I began to realize John was just like anybody else except he was afflicted with a horrible disease. All of the fears I had in dealing with AIDS patients were irrational. John's further medical evaluations revealed a CNS Lymphoma.

I looked forward to seeing John every morning because he was so pleasant to communicate with, more so than any other patient I have dealt with since then. John was in the hospital thirty days; we subsequently arranged for continuous nursing care for him at his mother's residence. John and his family wanted his last few days to be spent at home. I sincerely respected this sentiment.

The lesson I learnd from this experience is to put aside personal prejudices and pre-conceptions in the name of quality patient care. I feel very fortunate to have had such a pleasant experience with a terminal AIDS patient early in my medical training. AIDS has become such a common occurence that the medical profession has the duty to educate the public about the basics of the disease. Organized medicine has done a tremendous job in this pursuit over the years, but more can be done to allay irrational fears bout AIDS. John is no longer living, but the education he provided me is still alive. MoMed

Ask Your Doctor

Jean A. Chapman, MD, MACP

Ask Your Doctor has been one of the most successful activities of the Cape Girardeau County Area Medical Society in public education.

Ask Your Doctor is a live, hour-long, question and answer program which airs on TCI Channel 5 limited access television in Cape Girardeau on Thursday nights. The program has run continuously since 1990 with 316 programs.

This program is a win, win, win effort, popular with the public, supported financially by Southeast Missouri Hospital and Saint Francis Medical Center, with the enthusiastic volunteer participation by members of our medical society. In fact, so enthusiastic, our medical society had to pass a resolution that a member's appearance on the program be limited to twice a year. The physicians participate voluntarily and without compensation.

The mission of the program is to offer the public the opportunity to ask questions of the physicians who they would not otherwise have access. In addition, the intent of our medical society is to teach the public the latest information in various specialties and subspecialties to enhance their knowledge and understanding of specific medical diseases. It also offers the opportunity to discuss socioeconomic issues and presents the physician's view. This has been particularly valuable with the rapidly changing practice patterns initiated by managed care and state and federal legislation. It has given us the opportunity to become patient advocates, pointing out legislative issues especially bills before our congress and state legislature such as House Bill 335 and Senate Bill 223.

For the physician, there is the opportunity to discuss his/her field and give the public a view of his/her appearance, personality, and knowledge.

For the hospitals, the sponsorship is yet another demonstration of their outreach to the communities and is a unique opportunity to show the public various hospital-based services such as diagnostic MRI or CAT, open heart surgery, neurosurgery, diabetes education, cardiac and pulmonary rehabilitation.

Limited access television by virtue of the exclusive contract with the area served is required to have public service programs when the opportunity arises. TCI serves 13,000 households in the Cape Girardeau, Jackson, and Scott City areas.

The studio has props identifying the show as *Ask Your Doctor*. The guest physician completely controls what he or she wants to discuss. Fortunately, Martha Muench, a retired health reporter for the local CBS affiliate station, participates as a co-host with me.

Physician members of the medical society volunteer for specific dates and select their own subjects by calling the medical society's Executive Director who schedules the shows, sends notices to the newspaper, and sends copies of the notice to the participating physician and co-hosts the week before the program. The participating physician is contacted by Martha Muench during the week to see if there are special needs for the program such as props -- a heart model for a cardiologist or an eye model for an ophthalmologist; usually the physician brings his/her own models. I call the doctor the day of the show to confirm his or her appearance. The show itself is completely spontaneous and unrehearsed. We meet 30 minutes before show time and discuss the general nature of the subject to be discussed. Occasionally the doctor will have a video tape or slides he/she wishes to show as demonstration. These are taped before the show for presentation during the show. These are generally discouraged, as audiovisuals seem to diminish the number of call-in questions.

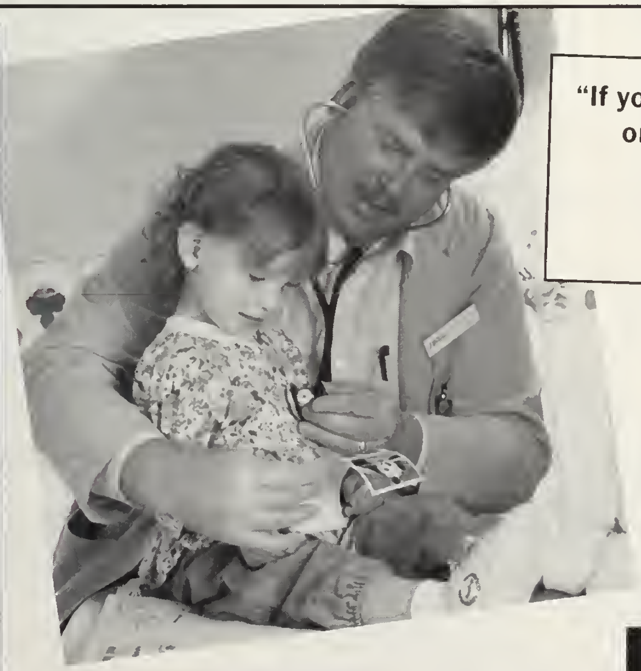
The board of the Cape Girardeau County Area Medical Society reviews and approves each program each month. Sometimes, physicians bring non-physician guests -- patients, dietitians, law enforcement officers, patient educators (diabetes), nurses, respiratory therapists or legislators which augment interest and breadth to the program.

The Cape Girardeau County Area Medical Society Alliance members, usually the spouse of the guest physician, assist by answering the telephone, writing the questions, passing them on to the camera operators who in turn pass them to co-host, Martha Muench. We learned early in the program, it is difficult to control the caller live on the air. Frequently, the caller would want to make a statement rather than ask a question, therefore, we answer the questions as they are written from their telephone calls. Callers frequently call back to clarify questions, so it is an active exchange of information.

Win, win, win: the public gains accurate up-to-date medical information, the physicians have voluntary public service opportunity for the public to see and learn from them and our sponsors, Cape Girardeau County Area Medical Society, Southeast Missouri Hospital, and Saint Francis Medical Center, carry on their mission of improving the health care of the public in the community. We encourage you to do this same kind of program in your area. **MoMed**

Suggested *Ask Your Doctor* programs:

- Family Medicine & Obstetrics
- Alternatives to Hysterectomy
- Child Abuse
- Preventive Medicine
- Mental Illness Awareness Month
- Sports Medicine/Orthoscopic Surgery
- Hyperactive Children
- Ear Disease
- Allergies
- Osteoporosis: Bone-Up Basics
- Summer Time Emergencies
- Urgent Care & Occupational Medicine
- Hospice Program
- Physiatry
- National Orthodontic Health Month
- Breast Cancer Awareness
- Total Joints
- Diseases of the Retina & Vitreous
- Physician Assisted Suicide
- Voice Disorders
- Children's Health Month
- Congestive Heart Failure



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Coleen Kivlahan, MD, MSPH
Former Director, Missouri Department of Health

In a civilized society, with all the wealth and prosperity most of us enjoy, it is easy to lose sight of one of our most valuable resources, the public health system. We need medical care some of the time, but we need a strong, effective public health system all of the time. Public health approaches have achieved remarkable successes in our country, state, and communities. Nationally, we can attribute much of the gains in smoking cessation, seat belt use, clean water and air, safe food, infant and children's health improvements, and infectious disease practices to public health approaches.

In Missouri, the Department of Health has cooperated with our public health system at the local level, the medical care system, and many private entities to achieve unparalleled success in the last four years. The four areas of concentration have been:

- Improving the Health of Missouri's Women and Children
- Protecting the Health of the Public
- Enhancing Customer Satisfaction and Forging New Public-Private Partnerships
- Improving Missouri's Health Care System

Successes in Improving Women's and Children's Health:

- Immunizations for Missouri's two-year-olds have improved from only 41% in 1992 to 75% in 1996. Our goal is to reach 90% of our children in the next year. In local health department clinics, we have already reached 78%.
- More than 36,000 uninsured women received pap smears and mammograms; 69 women were found to have breast cancer and 72 had cervical cancer detected.
- 192,000 children have access to school health services, many of whom are enrolled in schools that previously had no school nurse.
- The infant death and SIDS death rates are at a 15-year low in Missouri. Access to prenatal care has increased significantly in the same time period.
- Women's reproductive health services are more accessible, and abortions and unwanted pregnancies are dropping.

Successes in the Protection of the Public Health include:

- Cases of TB and syphilis, especially in babies, have dropped dramatically due to the state's commitment to strengthening public health efforts.
- Monitoring the dioxin incinerator burn at Times Beach has assured that citizens remain safe while a toxic waste site is eliminated.
- Missouri's groundwater and property are now protected through award-winning implementation of the new on-site sewage law.
- Federal AIDS funding is now successfully managed in order to maximize scarce resources for a population with special health needs.

Successes in Enhancing Customer Satisfaction and New Partnerships include:

- Citizens in 67 counties can obtain birth and death certificates easily in their own counties instead of traveling to Jefferson City.
- 7,000 Hallmark cards with an immunization message from the Governor are sent each month to new parents.
- In three counties in a new pilot program, WIC families and local farmers mutually benefit through the purchase of fresh fruits and vegetables with WIC vouchers.

Successes in Improving the Health Care System include:

- Four consumer guides have allowed citizens and health care providers to compare cost and quality of services, and be more informed in their health care decisions.
- 171 young doctors and nurses have received PRIMO funding for their education in return for service in an underserved area in Missouri.
- The CHART program has successfully encouraged more than 90 counties to engage in the process of assessing and improving their community's health needs.

Public health's role in the future will be to influence the establishment of health goals by providing data about what most affects people's health; to advocate for the allocation of resources based on what has the greatest impact on health status; and to promote consumer demand for those services that maximally promote health. Neither public health nor medial care can improve our citizens' health status alone. It will take all of us working together. We should all be encouraged by what we have been able to achieve so far, and inspired to set and achieve new goals for the next century.

To receive a copy of "Public Health . . . Working for Missouri," which includes *10 things you can do to improve the health of Missouri*, call 573/751-6001.

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Medical Records and Their Use in Litigation

John Wooddell, Attorney at Law

The maintenance of clear, accurate, contemporaneous records of patient treatment is necessary to support a high quality of patient care. As a secondary benefit, maintaining accurate medical records will serve the patient and the physician well when legal issues arise. This article is intended to review some of the obligations physicians have in connection with the creation and handling of medical records that may someday be used in litigation.

I. Rules Concerning Access To Medical Records During The Litigation Process:

The Rule of Confidentiality.

The obligation of the physician to keep the patient's information confidential is as old as the Hippocratic Oath: "... All that may come to my knowledge in the exercise of my profession ... , which ought not to be spread abroad, I will keep secret and will never reveal. ..." In Missouri, this principle has a basis in law as well as in medical ethics:

> We believe a physician has a fiduciary duty of confidentiality not to disclose any medical information received in connection with his\her treatment of the patient. This duty arises out of a fiduciary relationship that exists between the physician and the patient.

Brandt v. Medical Defense Associates, 856 S.W.2d 667, 670 (Mo. 1993). Accordingly, the information in a patient's medical records should be carefully guarded against unauthorized disclosure.[1]

Disclosure to the Patient.

When a physician receives a request for information in medical records, it is important to note who is making the request. The rules for disclosure may vary, depending on whether the request is made by the patient or by the patient's adversary.

By statute, a physician is obligated to furnish, upon request, a copy of a patient's medical records to the patient or his authorized representative. *R.S.Mo. §191.227*. The patient's request often precedes the commencement of any legal action and is a part of the investigation process that will determine whether the patient files a claim. When the request is made by the patient's lawyer, it will be accompanied by an authorization signed by the patient. This authorization will usually be very broad in scope, permitting the disclosure of all information in the physician's possession.[2]

The right to obtain a copy of his\her medical records is one that can be enforced by the patient. If a physician fails or refuses to furnish records in accordance with this statute, the patient may sue the physician for money damages. *Wear v. Walker*, 800 S.W.2d 99 (Mo. App. 1990).

Disclosure to the Patient's Adversary.

When a patient files a lawsuit for personal injuries, the law deems him\her to have waived the confidentiality associated with his\her medical treatment and medical records. However, this waiver may be a limited one; it does not automatically authorize disclosure of all the patient's medical records to his\her adversary. In almost all cases, the scope of disclosure to the patient's adversary will be defined for the physician by the terms of the written document — the medical records authorization —

signed by the patient in favor of his\her adversary (or the opposing attorney). The court will resolve any dispute about the scope of the waiver by requiring the patient to execute an authorization containing language appropriate for the particular case. The physician may rely upon the language of the authorization.[3]

II. Rules Concerning Use Of Medical Records At Trial

Admitting Medical Records in Evidence. Many written documents are inadmissible as evidence in court because they are considered "hearsay." Medical records usually qualify for admission under a statutory exception to the hearsay rule. This means medical records will generally be admissible in evidence so long as the appropriate foundation is laid to prove the records really are what they appear to be — contemporaneous records maintained in the ordinary course of your medical business.[4] Reports written after the period of treatment (usually at the request of a patient or a lawyer) may not qualify for admission because they are not contemporaneous records.

Presenting the Medical Records to the Jury. Once admitted into evidence, most trial judges will permit medical records to be read to the jury by the lawyer, to be read to the jury by a witness, or to be displayed by enlargement or projection. In any event, the actual language of the medical records will be before the jury.

Spoliation and its Consequences. Spoliation is the intentional destruction or alteration of evidence.[5] A claim of spoliation can arise if records are not kept for a reasonable retention period. More often, such a claim arises when there is a particular page or part of the record missing, or when there is an apparent alteration of the record. There are two likely consequences of spoliation of medical records, each of which can be very serious for the physician. First, the jury may be instructed that an inference may be drawn against the person responsible for records which were destroyed or altered; this, in essence, tells the jury to find against the physician on the issues in question. Second, many professional liability insurance policies exclude coverage when an insured is found to have destroyed or altered records; this, of course, leaves the physician's personal assets exposed.[6]

III. Some Practical Suggestions About Records Keeping

The following suggestions are offered for consideration in the design, implementation, and improvement of record keeping systems:

1. *Save records for a long while, especially when the patient is a child.* Statutes of limitations in injury cases range from two years (medical negligence cases) to five years (many other types of injury cases). For children, the statute in some cases can be "tolled" until age 18 or age 21, then run for two years or five years beyond that. If a child-patient has a claim against a third party that is asserted late in the statutory period, he\she will very much appreciate the fact his\her records have been kept. If a patient has a claim against his\her physician that is asserted late in the statutory period, the physician may be very glad he\she kept the records.
2. *Keep records current.* It raises a red flag in the mind of an investigating lawyer when requesting records weeks or months after treatment was rendered to be told "the doctor has not yet finished his dictation on that."
3. *If there is need to supplement a record that has already been completed, the new entry should be made with its own date and an explaination in the note it is an addendum.* A record that is already completed should not be altered. Information should not be filled in between the lines.[7] Any information already written should not be deleted or omitted.[8]
4. *When records are requested by a patient, the request should receive prompt and full response.* There is a statutory obligation to supply the information, and there is little to be gained by inquiring about why the records are being requested.
5. *When records are requested by the adversary of a patient, response to the request should be fair,*

Continued on page 170

Continued from page 169

but careful as to the scope of the information disclosed. This is a particularly sensitive issue in medical negligence cases, where a patient may be suing a physician's medical colleague. The extent of disclosure to the colleague and his attorneys tends to balance against the duty to a patient. The scope of disclosure should be determined by the authorization agreed upon by counsel (or directed by the court) and presented to the physician.

6. *In all medical records practice, it should be assumed a jury will someday see the records — in the process of evaluating a serious injury to a patient or even in the process of evaluating the physician's own conduct.* Carefully scripted prose is not required. Understandable notes, in typewritten form or a decipherable hand, are required. Defensive, self-serving statements will be recognized for what they are. Factual, fair-toned statements will serve the physician and his/her patients well. **MoMed**

The Author

John Wooddell is a lawyer with the Springfield, Mo., firm of Bruer, Wooddell & Bates. His practice is limited to representing plaintiffs in personal injury cases -- most commonly, in medical negligence cases.

References

1. New problems of confidentiality are created by widespread computerized access to records in the era of managed care. These problems and some technical solutions to them are discussed in: Sutherland, et. al., "High-Tech Gossip: Physician-Patient Confidentiality and Computerized Managed Care," *Trial* Magazine, November, 1996;pp. 58-63.
2. The physician may make a reasonable charge for providing copies of records. The charge may not exceed 35 cents per page, plus a $15 handling fee.
3. The question of whether a physician can (and should) discuss the patient's care with representatives of the patient's adversary -- the so-called "ex parte" conference -- is more complicated than the provision of medical records. It is beyond the scope of this article.
4. The foundation for the admissibility of medical records is usually laid by (1) calling, as a witness at trial, a custodian of the records from the physician's office, who identifies the records and testifies to their authenticity, or (2) obtaining an affidavit from the custodian, as authorized by *R.S.Mo. §490.692.*
5. An excellent discussion of spoliation issues may be found in Graham, et. al., "Spoliation of Medical Records," *J. Mo. Bar,* March-Apr., 1996;pp. 87-91
6. In addition to these consequences in the civil case, there may be criminal penalties involved for "tampering with evidence." See *R.S.Mo. §575.100.*
7. On one occasion, it was proven, through infrared photography, that suspicious looking insertions were, in fact, made with a different ink than the body of the note, and thus added at a different time.
8. On a number of occasions, records had been presented by a physician in court as "complete," but copies sent to others previously contained additional entries not present in the "complete" package.

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Radiology Quiz #11

Roger A. Francis, MD
Radiology Department, Lake of the Ozarks General Hospital

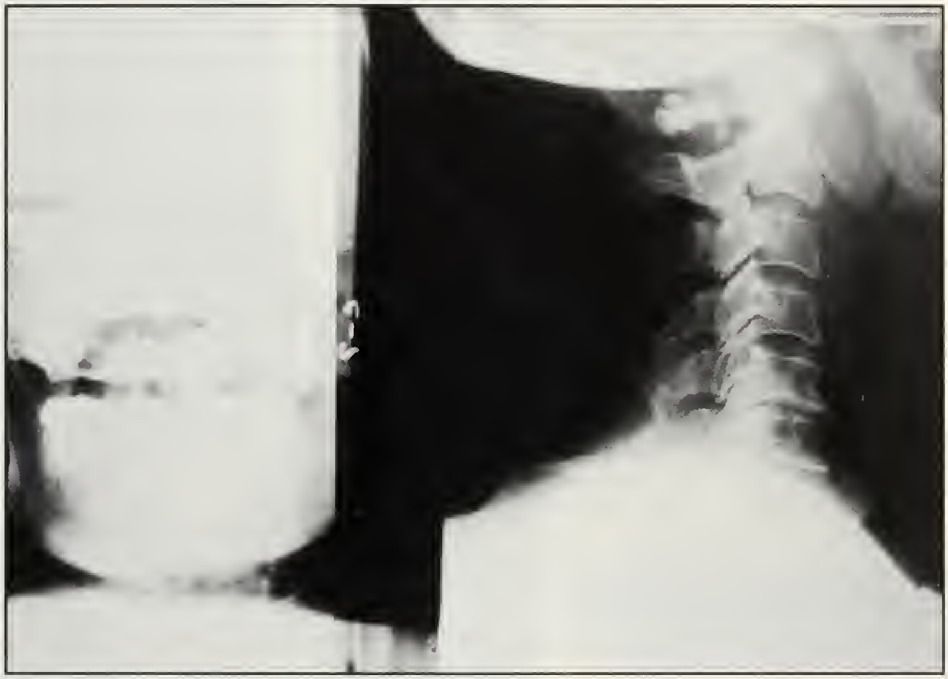


Figure 1

A 78-year-old male was brought to the emergency room after being struck on top of the head by a falling tree branch. The patient complained of neck pain, but no neurologic deficits were elicited. Plain radiographs of the cervical spine were obtained, with lateral and open mouth views shown (Fig. 1).

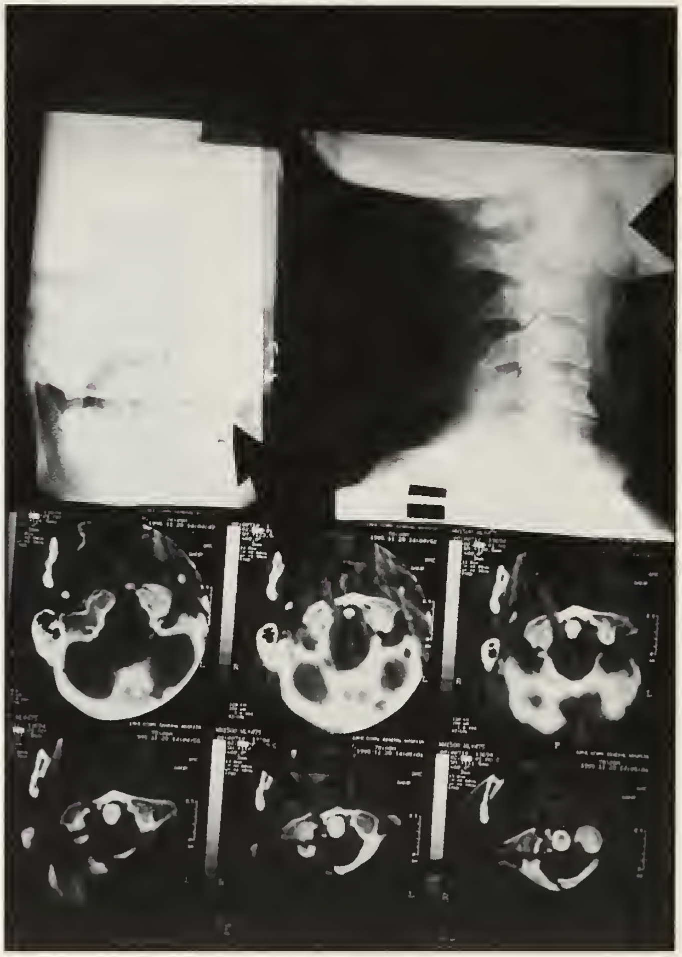
What is the diagnosis?

a. dens fracture
b. bilateral facet lock
c. hangman fracture
d. Jefferson fracture

(See answer on next page.)

The Radiology Quiz question is located on the previous page.

Figure 2



ANSWER: d. Jefferson fracture (burst fracture of C-1)

The lateral film of the cervical spine shows moderate widening (arrowheads) of the prevertebral soft tissue space at C1-2. In adults, the prevertebral space at C2 should be no more than 5 mm, but in this case measures 11 mm. The open mouth view shows slight lateral displacement of the left lateral mass of C1 in relation to C2 (large arrow). Due to the above findings, computed tomography of the cervical spine was performed, showing multiple fractures of the anterior and posterior arch of C1 (small arrows). This "burst" fracture of C1 is also known as the Jefferson fracture (option d is the correct response).

The Jefferson fracture occurs as a result of axial compression onto the skull vertex, resulting in outward force exerted on the C1 arch, and resulting lateral displacement of fragments. This accounts for the lateral offset of the lateral masses of C1 in relation to C2. Soft tissue hematoma due to fracture results in the widened prevertebral soft tissue space.

Option a, dens fracture is incorrect since the dens appears intact on lateral and open mouth views.

Option b, bilateral facet lock, is incorrect since vertebral alignment and facet joints appear normal on the lateral view. Facet lock usually is a consequence of a hyperflexion injury.

Option c, "hangman" fracture, or traumatic spondylolysis of C2 results from forceful hyperextension of the neck. The name of the fracture resulted in former times from the occurence of this injury in judicial hangings. Now, the fracture is more commonly seen in motor vehicle accidents. Since C2 appears normal, option c is incorrect.

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1. El-Khoury, G.Y.; Kuthol, M.H.; Daniel, W.W. Imaging of Acute Injuries of the Cervical Spine: Value of Plan Radiography, C.T. and Magnetic Resonance Imaging. *Am. Journal of Roentgenology* 1995;164:43
2. Rogers, L.R. ed. *Radiology of Skeletal Trauma,* 2nd Edition. Churchill Livingstone 1992;460-71.

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Developing a Partnership with a Practice Management Company

Deanna Peltz, Health Care Consultant

Like a meteor, public physician practice management companies have exploded into the medical marketplace. Since 1992, the number of such companies has skyrocketed from one to more than 30, involving 20,000 physicians compared to 500 just five years ago.

Should you develop your own partnership with a public physician management company? As with any other major decision involving your practice, the answer depends on your needs now and in the future.

Defining the Options

First, you should look internally to determine if a management company relationship is in your future. Managed care is becoming more sophisticated by the day, and the demand for clinical and cost data will only intensify. If you need help in these areas, need more leverage in managed care contract negotiations, or need capital for practice expansion, such a partnership may be for you.

Your options range from selling your practice outright and becoming employees to contracting for individual services, such as information systems management. You also have a range of choices, including partnering with a publicly-traded management company or affiliating with a management service organization (MSO).

You should know enough about your practice to determine whether or where you fit into this menu of choices. Each option offers varying levels of expertise and service. It's critical for you to sort out these options and determine what's best for you.

PPMCs and MSOs -- The Same but Different

Physician practice management companies (PPMCs) and medical service organizations (MSOs) are similar in some ways but different in others. PPMCs can be publicly traded companies, like PhyCor and MedPartners. MSOs generally are subsidiaries of major health systems, large group practices, and state medical societies, or a joint venture of hospitals and physicians.

Both entities can provide on-site management services, hire non-physician employees, and run the practice in every way short of providing direct medical care. MSOs and PPMCs offer any combination of the following partnership options ...

☞ outright purchase
☞ asset purchase/long-term management agreement
☞ management service agreement minus asset purchase
☞ individual services, such as billing or credentialing

With each partnership option, you should also consider governance issues to make sure your interests are well represented and that you maintain adequate oversight. The ideal situation calls for equal representation from the management company and the medical practice, with a majority vote required for major decisions.

Choosing the Right Management Company

After exhaustive research into your own practice, you've finally decided to approach a physician practice management company. On the other hand, you may have been approached by a PPMC.

What next?

Conduct even more research, this time into the background of your PPMC suitor. Publicly-traded physician management companies are still relatively new. Rapid growth sometimes puts the proverbial cart before the horse; in this case, the promises made by some PPMCs may be beyond their capacity to deliver.

You should evaluate the following when researching a prospective PPMC:

- ☞ Company Stability -- is the company well-capitalized? You'll need access to capital if you're planning an expansion or other major improvements, not to mention the money required to cover early operating deficits. Another factor to consider is the quality of people attracted by a well-run company; a well-capitalized company draws quality managers.
- ☞ Physician Orientation -- make sure your practice is a priority. Check out the PPMCs track record with physicians, even to the point of visiting a company-owned practice to see how things work.
- ☞ Incentives/Compensation Issues -- the company's success should depend on your success, not that of a hospital, investor or health plan. Properly structured incentives prevent conflicts of interest and encourage oversight by both parties on each other's performance. When it comes to compensation, you'll benefit more by sharing a percentage of the net income rather than the gross income. PPMCs generally charge management fees of 15-20% of income after expenses.
- ☞ Current Alliances -- the company may have in its corporate stable medical practices or hospital MSO systems which you compete against. Make sure you enter a situation where your interests will come first, now and in the future.
- ☞ Management Expertise -- look for a proven track record in management, information systems, and legal issues. Today's medical marketplace requires extensive experience in risk management.
- ☞ Strategic Vision -- this depends on the variables of your medical marketplace. In an area with a strong managed care presence, a management company would likely concentrate on contract management services, including credentialing, enrollment, and benefits eligibility. In a market with less managed care, more traditional services would be required, such as billing, group purchasing, and patient scheduling. Whatever the variables, both you and your new management partners need to be on the same page.

Making the Choice -- After the Fact

Once you've made your choice, it's important to get it in writing. Any agreement needs to address the governance issues discussed earlier, termination options, and include exclusivity language that prohibits the company from contracting with a competitor in a well-defined geographic area.

Liability issues need to be defined as well, indicating the level of insurance risk each party must carry for the others actions. Alternative dispute resolution language should be added which allows either party an informal process to resolve internal disputes.

Other legal issues are just as sticky. Referral and fraud and abuse provisions remain with Stark I and II still on the books. And while antitrust standards were recently relaxed by the Department of Justice, you still need to take care in terms of pricing and competitive behavior in your marketplace.

Even after all is said and done, you need to remember this -- you still maintain responsibility for your practice. Practice management companies bill for their services and through contracting and strategic planning can influence revenues in your practice.

Someone else is handling your money; don't fall asleep at the switch. MoMed

The Author

Deanna Peltz is a health care consultant for Mayer Hoffman McCann in Kansas City, Missouri. The firm is a member of the CPA Healthcare Network, an organization of CPAs with extensive expertise in the medical industry.

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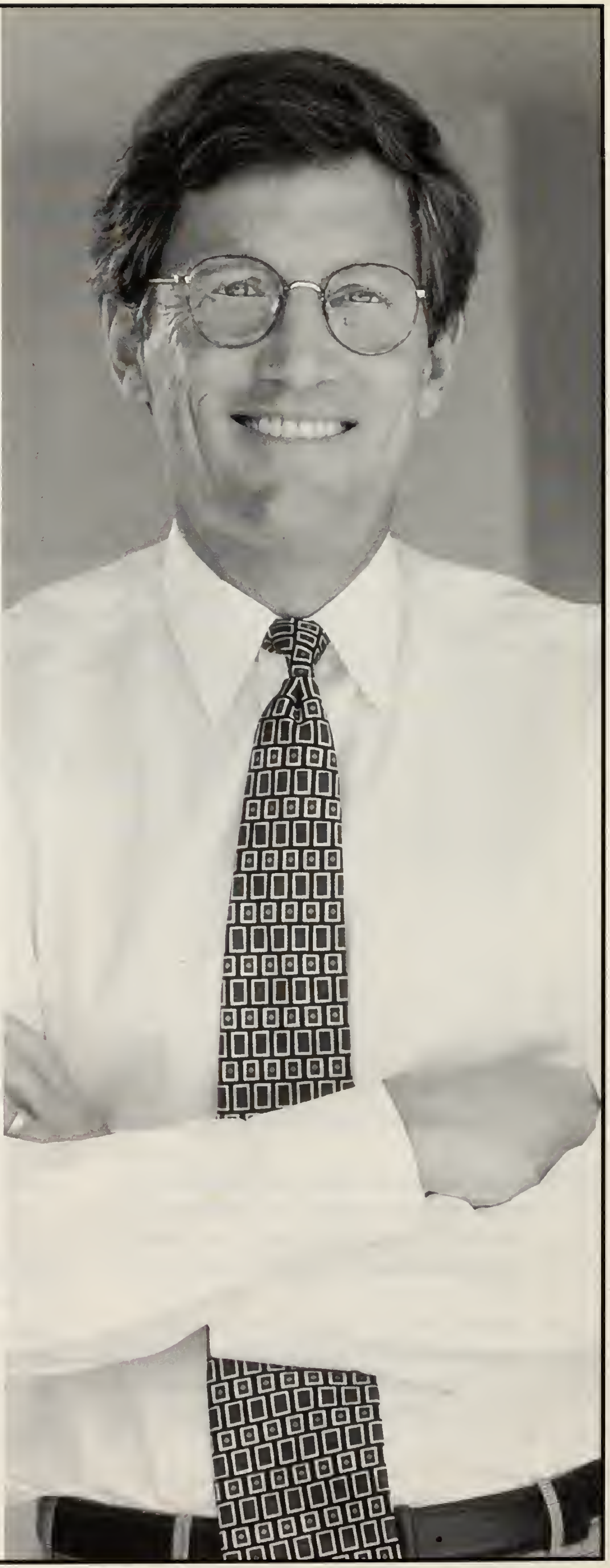

Putting Quality Improvement into (Your) Practice

Part Two

Gregg R. Laiben, MD

The first article in this series, which was published in *Missouri Medicine* in February 1997, introduced the concept of *continuous quality improvement* (CQI) to the reader and compared the process to that of the scientific method of experimental design. This month's installment will expand upon this base and begin to define specific aspects of CQI and provide examples of how these methods can be operationalized.

Another term to describe the improvement process is *total quality management* (TQM). For our purposes, the terms CQI and TQM are interchangeable. However, another frequently heard term is *quality assurance* (QA) which must be distinguished from CQI/TQM. QA primarily identifies individual problems in the patient care process. Performance goals are set and QA personnel focus on correcting the problem in order to reach the preset goals. Compare this process to CQI, which is a structured organizational process used to involve personnel in planning, analyzing, and implementing a continuous series of improvements in order to provide care that meets or exceeds the customer's expectations and demands. QA typically focuses on correcting singular problems, whereas the CQI perspective is global and stresses correction of processes so as to eliminate or minimize the occurrence of problems initially. QA is more retrospective and problem oriented, whereas CQI is prospective and oriented to improving the processes of care.

The Joint Commission on Accreditation of Healthcare Organization's (JCAHO) reliance upon standards used during hospital surveys for many years is an example of QA. As the CQI movement progressed through the late 1980s, JCAHO began to incorporate the CQI theme into its accreditation process and distanced itself somewhat from QA.

The concept of "customer" is central to the CQI philosophy and success requires a system-wide commitment by all participants. In the health care setting, a customer can be defined as anyone within the system who has dealings with others in the system. Every process undertaken in health care has an expected outcome for a given customer. For example, when ordering a patient x-ray exam, the attending physician furnishes the radiologist with clinical information to assist in the film's interpretation. This seemingly simple process involves at least three persons who must work in concert with each other to reach a successful outcome: the radiologist, the attending physician, and the patient. The patient is a customer to both the radiologist and the attending, while the two doctors each serve as one another's customer. The attending strives to provide the radiologist with the right amount and type of clinical information so as to receive the most accurate interpretation. Conversely, the radiologist wants to ensure the attending (and the patient) receive the best services.

A recent survey conducted by the Princeton Survey Research Associates noted the majority (87%) of respondents found comparative information useful when making various health care decisions. Unfortunately, many stated they did not have access to the necessary information, so they continued to rely on family and friends for assistance. Physicians desiring to position themselves for the future will keep these results in mind as they explore various

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opportunities to improve patient care. They must also understand the key is to communicate the improvements to patients in an objective manner and avoid reliance upon subjective appeals.

In the same survey, respondents were asked to compare various characteristics such as cost, access, quality of care, and range of benefits when faced with the need to choose a new health insurance plan. The majority (42%) chose quality as the most influential factor in their decision, while fewer than 19% of the sample ranked any one of the other factors as primary.

Therefore, an imbalance arises: the market's desire for quality of care information is contrasted with the generalized lack of availability of the necessary data. How is this imbalance corrected, *i.e.*, how can a practicing physician assure patient access to this data? The answer lies within medicine's grasp: office-based CQI efforts can begin to provide the quality information needed by both patients and other customers. As health care is driven toward the outpatient sector and away from the hospital setting, patients and payors alike will profit from the knowledge gained as a result of these efforts.

Given the foregoing, what opportunities are available to Missouri physicians for improving the processes of care for patients? Various national physician organizations, including the American Medical Association, are implementing programs for their members to accomplish this goal. The AMA's recently-launched American Medical Accreditation Program (AMAP) will accredit physician's offices and provide successful practices a "gold seal of approval." AMAP will be phased in over five years with phase one comprising credential verification, assessment of personal qualifications, and evaluation of the environment of care. CME tracking will be added in 1998, while phase two introduces CQI by adding patient satisfaction surveys in early 1999. Late 1999 will see core measures added for clinical performance and patient outcomes results. By 2001, the program will be fully operational with expansion of the clinical measures.

As AMAP unfolds its subsequent phases, preventive care will be stressed including early detection of diseases and appropriateness of clinical services. Although AMAP will obviously be *utilizing* clinical measures and guidelines in outcome studies, the actual *development* of the measures will be left to the experts in the field with subsequent adoption by AMAP.

An opportunity to improve care today and prepare the practice for the future is the performance of a preventive services project in the office. Early detection of breast cancer via screening mammography and/or self-breast examination is an ideal first project. Defining the proper patient population at risk for breast cancer is begun by reviewing the various guidelines available. Several entities, including the American Cancer Society, the National Institutes of Health, the American College of Radiology, and the U.S. Preventive Services Task Force, have scribed mammographic (and other) screening guidelines. The practitioner should review the various guidelines and choose one with which he/she is most comfortable. Although the vast number of available guidelines makes choice difficult, the fact remains the selection of a specific guideline is not nearly as important as making the original commitment to proceed with the CQI process.

The answer lies within medicine's grasp: office-based CQI efforts can begin to provide the quality information needed by both patients and other customers.

Once the clinical guideline is chosen, a baseline mammography screening rate should be calculated for your practice. To do this, select a small random sample of patient medical records (perhaps 50) which meet the specified criteria implicit in the guideline. For example, the guideline will define who should be screened for breast cancer, what screening method should be utilized, and the interval length between subsequent screenings. Selection factors include patient sex (female only in this instance), age (increasing age changes the interval between screenings), and co-existing or previous conditions (*e.g.*, a patient with a previous bilateral mastectomy does not require *screening* mammography).

Once the random sample has been identified, assess current adherence to the guideline by abstracting clinical information from the medical records of those patients identified in the sample; count each patient who has received a screening mammogram within the proper time frame. The number resulting from this tally serves as the numerator and should be divided by the total number of patients in the sample (50 in this example) who are eligible for the exam (the denominator). The fraction resulting from this calculation is the baseline screening mammography rate.

Many physicians will be surprised upon discovering a low screening rate in their practice. As a group, physicians tend to overestimate their adherence to consensus screening recommendations. However, from a positive perspective, the physician has identified an opportunity for improvement.

The next step involves detecting reasons why patients are not receiving the necessary screenings. A team approach, involving all members of the office staff, provides opportunities for sharing each other's experiences. The team should meet without interruption, so perhaps the schedule can be arranged for the office to close on a slow afternoon to meet. This session can start with brainstorming, a technique devised in the 1930s as a means to help groups generate a great variety of ideas. One person should act as a facilitator to keep the group on topic (not necessarily an easy task).

A flowchart (a step by step diagram of a process) can outline the entire chain of events surrounding a referral of a woman for a screening mammogram. Once this series of steps is clarified by the group, they can begin to identify problematic areas. Examples encountered in many practices include missed opportunities to discuss screening, failure to ask about screening, confusion as to who is responsible for screening, and scheduling conflicts.

Once specific problem areas are identified, solutions can be discussed. Solutions should be realistic and have a great likelihood to bring about a positive change, yet can be amazingly simple:

- ✔ exam room posters describing prevention of breast cancer are helpful to increase patient awareness;
- ✔ programming the billing computer to flag eligible patients at yearly intervals (or some other predetermined time) to send a reminder notice;
- ✔ stickers affixed by a nurse to the front of patients' chart to remind the physician to inquire about screening status.

These are only a few examples of possible interventions to improve screening rates. Research has shown that automation of routine tasks similar to those described above, results in demonstrable successes in screening program rates. Furthermore, lest one confuse this approach with "cookbook medicine," today's physician is required to maintain a knowledge inventory surpassing their predecessors by a great margin. Therefore, automating a process leaves less to chance and allows the physician to devote his or her attention to matters requiring high cognitive functions.

Ample time should be allowed for full implementation of the process changes, so that an increase in screening rates can be perceived when remeasurement occurs. At that point, the group can rejoice in their success and decide what other opportunities for improvement exist. Most importantly, patients will reap the benefits of CQI and the practice has produced objective information with which to demonstrate quality care. MoMed

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Making Sense of Antitrust Policy: Its Application to Physician Directed Networks

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"My way of fighting the competition is the positive approach. Stress your strengths, emphasize quality, service, cleanliness, and value, and the competition will wear itself out trying to keep up." Ray Krok, Co-founder of McDonalds Restaurants.

This paper is an outgrowth of organizational meetings that have been held with physicians throughout the state as they attempt to form Physician Directed Networks (PDNs). In the course of these organizational meetings the physicians have expressed their confusion, frustration, concerns, and anger over antitrust laws and guidelines. The outcomes of these discussions are reflected in this article.

Antitrust law is indeed a vast, confusing, and complex topic whose laws and guidelines are often focused on the following three areas:

- Price-fixing
- Boycotting
- Monopolization

This paper is not meant as an academic treatise on the merits of antitrust law and policy, but rather it is intended as a basic guide to assist physicians in their general understanding of the antitrust laws as they impact the development and operations of PDNs.

Nota Bene: there are many gray areas in interpreting the antitrust laws and guidelines, and this paper should NOT be used to replace legal counsel, but rather should be used in conjunction with legal counsel to better understand the spirit, meaning, and applications of the antitrust laws and guidelines as they impact physicians' organizational efforts with regard to PDNs.

With the passage of the Sherman Act (1890), the Clayton Act (1914), and the establishment of the Federal Trade Commission (FTC) (1914), the prevailing economic theory about business structure and behavior was codified and enforced during this period. It was Congress' and the courts' adamant belief at this time that competition would be injured to the detriment of consumers by the agreed elimination of rivalry, via cartels or monopolistic mergers, or by large companies driving out competition through predatory pricing. [1]

The key provisions of the relevant laws are stated below:

Section 1 of the Sherman Act (15 U.S.C. # 1) "Every contract, combination in the form of trust otherwise conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared illegal."

Section 2 of the Sherman Act (15 U.S.C. # 2) "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person, to monopolize any part of the trade or commerce among several states, or with foreign nations, shall be deemed guilty of a misdemeanor. "[2] (This penalty has now changed from a misdemeanor to a felony.)

Section 7 of the Clayton Act (15 U.S.C. # 18) "No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital, and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce in any section of the country, the affect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly. No person shall acquire, directly or indirectly the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of one or more persons engaged in commerce or in any activity affecting commerce, where in any line of commerce in any section of the country the effect of such acquisition, of such stocks or assets, or of the use of such stock or assets, or of the use of such stock by the voting of proxies or otherwise, may substantially to lessen competition, or to tend to create a monopoly."[3]

Because the Sherman Act and the Clayton Act are written in such vague terms they do not provide the necessary guidance as to how the law is applied in a particular set of circumstances. Further compounding the problem is that only a small body of case law is available as it applies to the health care industry, due to the fact that the application of antitrust laws to the health care industry is a relatively new phenomenon.[4] Therefore, in order to assist in the interpretation of antitrust laws, in September of 1994 and August of 1996, the Justice Department and the Federal Trade Commission (collectively, the "Agencies") published "Statements of Antitrust Enforcement Policy in Health Care."[5] Under this new policy, antitrust regulators will apply a more flexible "rule of reason" standard to a wider range of PDNs. In commenting on the new policy, the FTC Chairman Robert Pitofosky stated, "the new policies would ensure that the antitrust laws do not unnecessarily impede market development," but also added that "the revisions would not help physician networks that are nothing more than naked price-fixing."[6]

Below is a listing of the key topics that MUST be addressed by legal counsel and consultants with the physicians/clients in their efforts to organize into PDNs:

- Collective Bargaining/Price-Fixing
- Rule of Reason/Per Se Guideline
- Boycotting
- Market Power/Size (Monopolization)
- Competition
- Assumption of Financial Risk
- Exclusivity/Non-Exclusivity
- Clinical and Operational Integration of PDNs as Joint Ventures
- Improved Efficiencies Through Clinical and Operational Integration.

Boycotting

Boycotting can occur when providers collectively agree to withhold doing business with a competitor/payor. The implication is that physician members of a PDN could potentially tie up the market for their services, and thereby refuse to conduct business with those who do not meet their needs. This control, therefore, could have a negative impact on the consumer.

A PDN that is non-integrated (a term that is used under antitrust laws and guidelines) is, therefore, likely to be in clear violation of the antitrust laws if its board, membership or committees have discussed, approved or is currently engaged in a strategy to COLLECTIVELY boycott a payor or insurance carrier/managed care organization that is either currently conducting business, or attempting to conduct business in the PDN's community.

The rationale behind this likely result is the PDN as a group of competitors, is attempting to exert force on a payor, and in so doing, could have a detrimental impact on the consumer.

However, physician members of a PDN may choose as INDIVIDUALS not to conduct business with a payor, on condition that there has been no prior agreement among the physician members of the PDN to do so.

One key term in predicating the violation of the antitrust laws and guidelines is the term COMPETITORS.

Nota Bene: It must be clearly understood that physicians who are members of a non-integrated network, (i.e., one where there is no financial risk assumed, or where there is no substantial clinical or operational integration), are viewed by the FTC and the Justice Department as COMPETITORS, and therefore in violation of the law if they collectively boycott.

This issue of boycotting can be a rather emotional issue with physicians, particularly those who are not inclined to conduct business with managed care organizations. Some physicians may think it is their responsibility to protect the community/patients from the perceived threat of managed care organizations. They may, therefore, attempt to form a PDN for the purpose of keeping managed care out of their communities. Under these circumstances, the formation of such a PDN would likely be illegal.

Market Power/Size (Monopolization)

An analysis of market size is necessary to determine if an organization such as a PDN has such "market power" (i.e. has the power to control prices or control the competition in a relevant geographic area). In defining the market, or rather the service area, an antitrust analysis should be conducted that should include information regarding all the locations that patients travel to visit physicians for health care.

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Nota Bene: in determining market size, it is NOT the percentage of the total number of physicians within a community that is the key indicator for compliance or non-compliance with the antitrust guidelines, but rather the percentage of the total number of physicians by specialty within a relevant geographic/service area.

A PDN that has an exclusivity policy, (i.e., one that does not allow physicians in the network to join other networks) may invite antitrust scrutiny and enforcement if it has more than 20% of the physicians by specialty in a service area. For non-exclusive networks the percentage that may invite scrutiny is more than 30%.

Example: If patients who live in Mexico, Missouri travel to Columbia, Missouri to visit physicians, then Columbia must be considered as part of the relevant service area of Mexico when calculating the specialty component of the network.

The raw percentages, however, do not necessarily tell the whole story. Networks may have to go way beyond the 20% and 30% standard in order to create the economies needed for more efficient operations, and thereby, more affordable, more accessible and better available health care benefits for the consumer. If networks can achieve this, and are able to demonstrate and document this, then agency approval is likely. Such economies and efficiencies are generally attained via “substantial operational and clinical integration.”[7]

Collective Bargaining/Pricing

Pricing is one of the thorniest issues that confront physician members of PDNs. Physicians often join PDNs for the primary purpose of collectively bargaining for services (i.e., getting better pricing/terms as a group rather than negotiating as individuals). However, if physicians are not substantially integrated clinically or have not assumed financial risk, it may be illegal for the group to bargain collectively, which further implies that the physicians have discussed fees among themselves. This activity is often regarded by the Justice Department and the FTC as price-fixing, and, therefore, anti-competitive, because the physician members are deemed to be competitors with each other. If the physicians are sharing prices it may be construed as collusion for the purpose of fixing prices.

Networks that are non-integrated or integrated short of the required guidelines have as a recourse the “Messenger Model” to facilitate contracting between providers and payors. The “messenger” is a third party who may be a consultant, attorney or other independent third party who represents each physician in the network.

In a loosely integrated or non-integrated PDN, typically the “messenger” requests from each physician in the PDN a range of prices for the physicians’ major CPT codes, or a conversion factor, or RBRVS multiple. The messenger is then able to design a method (matrix), and may be able to determine a “no lower than” strategy to take to the payor. The “messenger” then reports back to each individual physician or group practice, and informs the provider of the payor’s offer. Generally there is a time frame in which the provider has to respond.

Exemptions

Despite the many hurdles imposed by the antitrust laws in establishing and operating PDNs, physicians may be able to have their activities reviewed under a “rule of reason” analysis (as compared to a conclusion of per se illegality), if they follow, and to the extent possible, document compliance with the basic rules described below:

- That the physician members of the PDN assume financial risk of over utilization in contracting with payors via capitation, global fees, and withholds.
- That there should be a certain degree of operational integration of the members of the PDN through such activities as the formation of a Management Service Organization (MSO) to provide common operational services like centralized billing and administration, group purchasing, marketing, to the membership in order to provide efficiencies in the delivery of services, which ultimately would benefit consumers through better access and lower costs.
- That there should be a certain degree of clinical integration of the members of the PDN that will also provide and demonstrate efficiencies in the delivery of services to consumers. Clinical integration may be demonstrated via “an active, ongoing program to evaluate and modify practice patterns by the physicians.”[8] Such programs may include utilization management and quality improvement that will provide more efficient and effective ways to control cost, improve the quality of care and, create better access to services.
- That a sizeable capital contribution by the participating physicians in the network is a further indication of the financial risk on the part of the physician members.

- That in the evaluation of market size, the actual service area rather than the immediate geographical community must be clearly defined. An analysis, therefore, should be conducted to determine where patients actually go for care and who provides that care, (i.e., patient origin studies by zip code). This analysis will assist in determining the actual number of specialists in this service area that are offering their services.

This market analysis is also important because it can show the amount of out-sourcing of health care from a particular community, and its economic impact on the community and the inconvenience caused to the patients/caregivers of that community.

Examples

The following are a series of examples that are meant to assist physicians in interpreting the antitrust laws and guidelines:

Example # 1: The contracting committee of a loosely integrated network, (i.e., one with no substantial financial or operational or clinical integration), meets to discuss a contracting strategy to recommend to the board and the membership. The physicians collectively decide that they will accept anything above 1.5 of RBRVS.

This action likely violates the antitrust's laws under a "per se" analysis because the physician members of the PDN are regarded as competitors, and may therefore presumed to be colluding to fix prices.

Example # 2: The contracting committee of a loosely integrated network, (i.e., one with no operational and minimal clinical integration but is prepared to accept financial risk), meets to discuss a strategy to recommend to the board and the membership. The physicians collectively decide to accept 1.5 of RBRVS with a 15% withhold.

This action would likely be acceptable and subject to the "rule of reason" analysis because the members of the network have entered into a financial risk arrangement per a substantial withhold.

Example # 3: The contracting committee of a more tightly integrated network, (i.e., one with an active and effective utilization management program), meets to discuss a pricing strategy to recommend to the board and the membership. The committee collectively decides to accept 1.5 of RBRVS.

This action would likely be acceptable and be subject to "rule of reason" analysis because the members of the network are using a utilization management program to create more efficient modes of service delivery which should have a beneficial impact on the consumer.

Example # 4: A messenger uses the fee information of the members of a loosely integrated network to develop a fee schedule for payors. If the payor accepts this schedule the messenger reports back individually to each member/group for the approval or rejection.

This action would likely be acceptable and subject to "rule of reason" analysis under the guidelines because the decision to accept or reject the payors offer is made INDIVIDUALLY by each physician.

Example # 5: A messenger requests fee information from the members of a loosely integrated network. The messenger then decides to pursue a strategy that would get the best possible deal for the members regardless of the pricing data that has been provided by the physician members.

This action would likely be a "per se" violation of antitrust laws because the messenger is collectively bargaining for the members of the network who must be regarded as competitors.

Example # 6: The contracting committee of a more tightly integrated network, (i.e., one with centralized billing and an active Management Service Organization), meets to discuss a pricing strategy to recommend to the board and the membership. The committee collectively decides to accept 1.5 of RBRVS.

This action would likely be acceptable and fall within a "rule of reason" analysis because the members of the network have established substantial services to create more efficient modes of service delivery which arguably should have a beneficial impact on the consumer through lower costs.

Conclusion

Physicians should be encouraged to continue their efforts in organizing into PDNs despite the difficult process of complying with antitrust laws and guidelines. However, it is advisable for PDNs to develop a progressive plan for the integration of clinical and operational services and progressively assume financial risk in order to substantially effect the changes and efficiencies that are necessary to compete for patients.

"The winners in health care delivery in the coming years, therefore, will be will be those organizations which understand the dynamics of transformation

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currently underway and those which can identify and adopt effective strategies to respond to these changes."[9]

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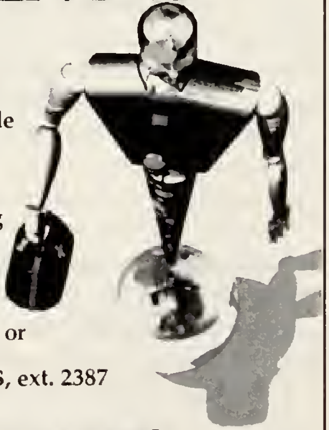

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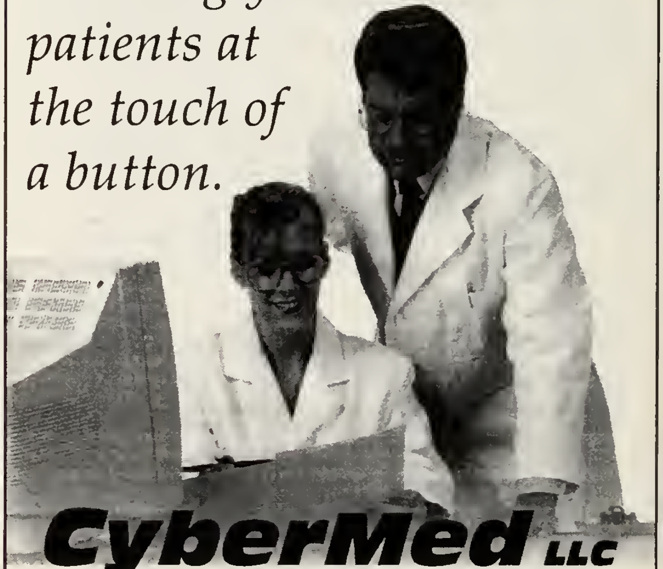

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Dartmouth Atlas of Health Care Missouri

Patrick J. Mills, MBA, CPA
MSMA Director of Health Care Finance

Key: 1 physician per x number of patients

City	Cape Girardeau	Joplin	Columbia	Springfield	Kansas City	St. Louis
Population	253,402	311,296	587,088	619,065	2,025,703	3,134,871
All Physicians	769 #	721	593	704	561	560 *
Primary Care Physicians	2,004 #	1,776	1,605	1,845	1,538 *	1,592
Specialists	1,255 #	1,218	948	1,147	889	876 *
Anesthesiologists	14,085	18,868 #	11,494	14,286	10,870 *	11,628
Cardiologists	29,412	32,258	20,833	33,333 #	21,277	17,857 *
General Surgeons	10,753	11,905	11,364	10,870	12,346 #	10,204 *
OB/GYN	11,111	8,621	10,101	12,195 #	9,524	8,065 *
Ophthalmologists	27,778 #	24,390	24,390	26,316	17,241 *	17,544
Orthopaedic Surgeons	31,250 #	17,241	14,925 *	16,949	14,925 *	15,873
Psychiatrists	18,519 #	17,544	10,204	16,949	8,929 *	9,615
Radiologists	14,925	13,889	11,765	15,152 #	11,765	9,901 *
Urologists	33,333 *	35,714	38,462 #	37,037	34,483	35,714
Resident Physicians	8,333	10,870	1,786 *	10,989 #	2,747	2,041

* = lowest ratio
# = highest ratio

Observations

- The recently published Dartmouth Atlas of Health Care contained the data listed above. The most populous cities in Missouri, St. Louis and Kansas City, usually have the lowest ratio of patients to physicians in all specialties listed. Surprisingly, general surgeons in Kansas City have the highest ratio in the state.

- Cape Girardeau, which is the smallest city listed, generally has fewer specialISTS, but has more urologists per capita than anywhere else in Missouri.

- Columbia, the smallest of the cities with medical schools, had the lowest ratio for residents and orthopaedic surgeons and the highest for urologists.

Does Pulmonary Airway Inflammation Relate to Intercellular Adhesion Molecule (ICAM-1) in Bronchoalveolar Lavage Specimens?

A Pilot Study

Ashwin Rumalla, MD; Betty Herndon, PhD;
Dennis Pyszczynski, MD; Padma Suvarna

Abstract

Background: The objective of this study was to assess the value of intercellular adhesion molecule-1 (ICAM-1) levels in bronchoalveolar lavage (BAL) specimens.

Methods: BALs from 44 unselected patients undergoing routine diagnostic bronchoscopy with bronchoalveolar lavage were studied. Cell-free supernatants of the BAL specimens were frozen at -70°C until tested. BAL ICAM-1 concentration was measured using enzyme immunoassay and degree of patient illness assessed by modified APACHE II scores.

Results: ICAM-1 in BAL fluid was positively correlated to the patient illness score (modified APACHE II) at a p value of 0.026. No such association was found between ICAM-1 levels and cigarette use or infection with *pneumocystis carinii*, although a few individuals in the smoker's group with pulmonary infection had 10-fold elevations of BAL ICAM-1.

Conclusions: BAL ICAM-1 may relate to the pulmonary pathogenic process as supported by the association between modified APACHE II scores and ICAM-1 values. Specific pulmonary-related diagnosis and BAL ICAM-1 did not produce significant relationships in this study.

Introduction

Identification of inflammatory markers in bronchoalveolar lavage (BAL) specimens has proved useful in several diseases; assessment of these markers in BAL has been used at times to follow both disease course and response to therapy. One such inflammatory marker, ICAM-1, appears to be particularly important in pulmonary airway inflammation[1-4] having been detected in the BAL of patients with interstitial lung diseases and on bronchial epithelium in reactive airway disease. ICAM-1 is a 80-115 kD glycoprotein with distinct binding sites, particularly on activated leukocytes. Upregulation of this molecule has been reported in virally-infected tracheal cells[5-6] and in inflamed bronchial epithelium in asthma[7]. It was of interest to determine if a marker such as ICAM-1, widely found on activated cells, would be elevated in patients diagnosed with pulmonary disease at a major Missouri metropolitan area medical center. This study evaluated the ICAM-1 in BAL of patients undergoing diagnostic bronchoscopy and compared the values obtained to markers of pulmonary airway inflammation or overall pulmonary illness. Our study illustrates the relevance of the emerging science of using cytokine levels as diagnostic tools for the general practitioner. Current updates on new methods of diagnosis allow for quicker evaluation and implementation of treatment for the patient.

In the first group, smokers, the question we asked was: Will pack-years of smoking relate to expression of elevated ICAM-1? Exceptionally elevated BAL ICAM-1 was found in a few of these patients, all of whom had pneumonia. A second group of 21 BALs was then collected which included specimens from patients with bacterial pneumonia, *pneumocystis carinii* pneumonia (PCP), or no diagnosis of infection. The question asked in group II was: Based on pilot measures showing elevated BAL ICAM-1 in patients with pneumonia, will elevated measures occur in a second more ill group? Will modified APACHE II scores (reflecting overall degree of pulmonary illness) correlate with the BAL ICAM-1 level?

Methods

Population: The cell-free BAL supernatants from 44 unselected patients undergoing routine diagnostic BALs were obtained. Twenty-three were involved in the pilot study and 21 in the subsequent investigation. All patient samples were from routine diagnostic BALs, thus there was no inclusion or exclusion criteria. Permission was obtained from the IRB to utilize BAL specimens left from diagnostic tests and to review charts. The IRB waived the need for informed consent.

Measurement of ICAM-1: The cell-free BAL supernatants from all patients were frozen at -70° Celsius until batch-tested. An enzyme immunoassay test kit for human ICAM-1 (T-Cell Diagnostics, Inc., Cambridge, MA 02139) was used to measure BAL ICAM-1. Procedures for the ICAM-1 assay were followed according to the manufacturer's instructions. BAL was assayed undiluted. Results were read on a Dynatech microplate reader at 490nm and ICAM-1 values were established with automated curve fitting software.

Review of Patient Records: The pilot group included 23 sequential diagnostic BALs, mostly from smokers. Charts were evaluated for pack-years of smoking and diagnosis. The second group of 21 patients included 11 patients who presented to the hospital with primarily pulmonary findings (x-ray infiltrate, cough, dyspnea). The degree of pulmonary illness in these individuals was estimated by use of a modified APACHE II score[8]. The APACHE II classification system has been validated in its association with hospital mortality in many studies involving patients in intensive care units. Each scoring criterion was given a number based on initial presenting symptoms and initial lab work. The 10 other patients of this group had suspected infections outside of the respiratory tract. Therefore, comparison between their BAL ICAM-1 and infection score was not performed.

Correlations of ICAM-1 with Pulmonary Illness: This study measured a quantifiable marker found on activated BAL cells, ICAM-1, in patient populations with the objective to formulate hypotheses about clinical correlations. In the first group consisting of heavy smokers, (Group I), ICAM-1 in the BAL supernatant was correlated by linear regression to the number of pack-years smoked. For patients with uniquely elevated ICAM-1, specific diagnosis was noted. In the subsequent Group II, patients were divided by pulmonary infection, found to be a significant trigger for ICAM-1 in Group I, as well as by overall pulmonary illness compiled as a single number by a modified APACHE II scoring.

Statistical measurements: ICAM-1 values were compared intra-group between diagnoses (smoker-no smoker) using nonparametric analysis (Mann Whitney; Chi Square). APACHE II score was compared to BAL ICAM-1 by linear regression, calculating both significance and 95% confidence levels. Presence of infection with *pneumocystis carinii* in both groups was evaluated for preferential rise in BAL ICAM-1 by analysis of variance and suitable post-hoc tests. Statistical calculations utilized the INSTAT2 program (Graph Pad, Inc.). A p value <.05 was considered significant.

Results

Chart review indicated that in Group I, smokers, eight of the 23 were diagnosed with pneumonia, seven PCP pneumonia and one with bacterial pneumonia. The ICAM-1 in the infected individuals showed significant higher ICAM-1 when compared to the uninfected smokers. (p = 0.038, Mann Whitney 2 sample test).

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Two of the PCP pneumonia patients had ten-fold elevated BAL over the uninfected patients.[10] On the other hand, our premise that lung cell activation would relate to pack-years smoking was not shown by the data. ICAM-1 BAL values (ng/mL) were plotted against pack-years of cigarette smoking and were found not significantly related (Fisher's Exact Test, p = 0.41).

Group II consisted of 21 patients, all of whom were given diagnostic BAL. On all inpatients BAL ICAM-1 values were compared with each patient's modified APACHE II score by linear regression. The APACHE II scoring has been validated in many critical care settings and offers the opportunity to assign a single value representing many clinical measures. As illustrated by Figure 1, a positive correlation was found between modified APACHE II scores and BAL ICAM-1 levels (p = 0.026). Also in Group II, patients in whom the specific diagnosis of PCP had been made were evaluated for ICAM-1 BAL levels. The BAL ICAM-1 values for Group II patients with PCP were 9.72 ± 1.24 ng/mL compared to 10.6 ± 1.68 ng/mL for the 18 remaining patients. The ICAM-1 scores were not significantly different (p = 0.23, Mann-Whitney test). No exceptionally high ICAM-1 values were found in Group II, as was seen in the smokers, Group I.

Discussion

These measures sought to find, in a group of patients with diagnostic BAL and possessing a

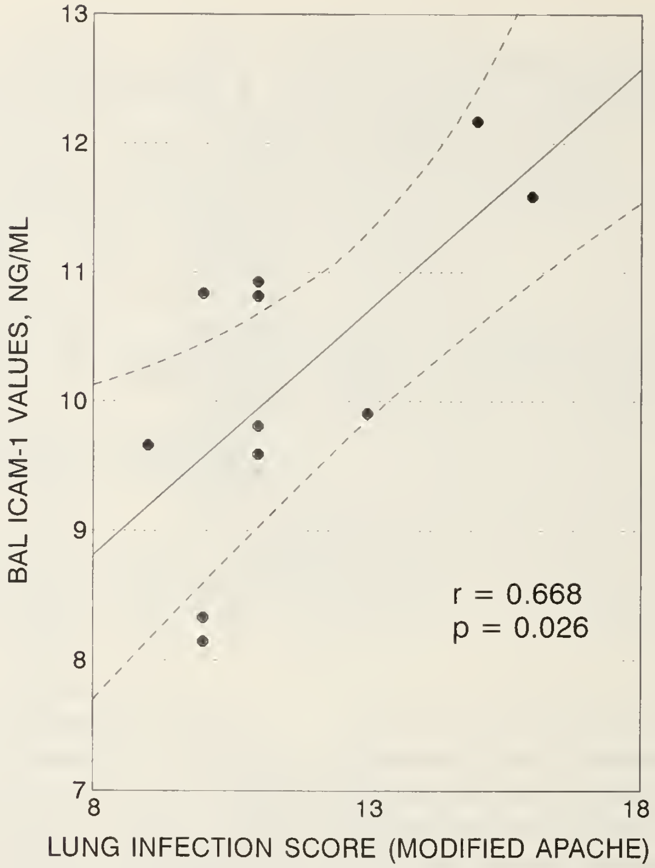

Figure 1. Relationship between ICAM-1 and acute clinical condition as scored by modified APACHE II. All inpatients of Group II were included (input values for APACHE II wereunavailable on outpatients). The modified APACHE II score included measures of immature neutrophil counts in addition to the usual critical care scoring for patient temperature, respiratory rate, blood pressure, immunosuppression and other signs. The score for all inpatients correlated positively with the ICAM-1 (ng/mL) in the broncho-alveolar lavage fluid (significance by linear regression analysis, p = 0.026).

Table 1. Infectious Lung Conditions Found in BAL Diagnoses and ICAM-1 Levels

BAL Cytology Diagnoses		ICAM-1 ng
Patient #4	PCP	12.897
Patient #6	Recurrent LLL pneumonia	10.187
Patient #9	PCP	105.648
Patient #11	PCP	3.245
Patient #13	PCP	9.886
Patient #16	Bacteria	157.515
Patient #18	Bacteria	29.984
Patient #20	PCP	302.901
Patient #21	PCP	15.906
Patient #22	PCP	18.463

ICAM-1 for the group of 23 as a whole averaged 11.2 ± 1.30 ng/mL in BAL supernatant. The seven PCP patients' BAL ICAM-1 averaged 66.99 ± 41.51(SEM) ng/mL. This difference is significant, Mann Whitney 2-sample test, p=0.038. The other 13 BALs' cytology showed tumor cells or were non-diagnostic.

history of pulmonary insult, whether BAL ICAM-1 would relate to lung illness. We first rejected the initial premise that ICAM-1 in BAL is a marker of a specific risk factor. The absence of a relationship between ICAM-1 and pack-years smoking and the variable results associated with PCP supports such a conclusion.

It may still be suggested however, that based on the data, ICAM-1 in BAL relates to the pulmonary pathogenic process. A significant correlation was found between modified APACHE II scores--the degree of acute clinical disease--and BAL ICAM-1.

The Group I data implied that high BAL ICAM-1 related to infection in some patients: ICAM-1 freed from cells and in the alveolar area was found in high amounts in some of the patients with acute lung infections. On the other hand, those patients with pulmonary problems of a chronic nature, even with a 60 pack-year smoking history, perhaps colonized but not acutely reacting, did not exhibit high ICAM-1 in BAL.

Exceptionally high BAL ICAM-1 noted in the infected patients of Group 1 may not have been all that unusual. For example, Kojima et. al. found that raised soluble ICAM-1 in tracheal aspirates of infants correlated with the subsequent development of bronchopulmonary dysplasia[10]. In bronchial epithelial cell culture, several inflammatory mediators stimulated ICAM-1 expression[11]. These mediators are often induced by active infection. There is the additional possibility that this inflammatory marker is elevated somewhat in pneumonia and that a synergistic effect occurred in the small group who were also heavy smokers.

In summary, several pulmonary risk factors and a modified APACHE II score for clinical disease have been evaluated in patients on which BAL ICAM-1 was measured. The overall score for acute clinical disease showed a significant relationship to BAL ICAM-1. Greatly elevated ICAM-1 in a few patients with PCP was seen, which could not be explained by these experiments. Our limited sample size makes it difficult to assess the overall clinical significance of these measures in pulmonary care. Perhaps future studies with larger sample sizes would allow for better elimination of confounding variables which may, in themselves, influence BAL ICAM-1 levels. MoMed

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Membership Notes

Gregg R. Laiben, MD, Missouri Patient Care Review Foundation Medical Director, will give a presentation at "Primary Care Update 1997: Issues and Answers" sponsored by the Southern Medical Association. The conference will be held in Nashville, Tenn., June 13-15, 1997. Dr. Laiben's topic will be "Quality Improvement."

Lucian V. Del Priore, MD, PhD, received a $978,484 four-year grant from the National Eye Institute for a research project titled, "Transplantation of the Retinal Pigment Epithelium." Dr. Del Priore is an assistant professor of ophthalmology and visual sciences and biochemistry and molecular biophysics at the Washington University School of Medicine in St. Louis.

In Memorium

Katherine S. Brown, MD, 86, Overland Park, Kan., died February 3, 1997. She graduated from Washington University School of Medicine in St. Louis in 1934. She practiced medicine and lived in Fulton until 1990, when she moved to the Kansas City area. Dr. Brown was a member of the Missouri State Medical Assocation.

Vance E. Link, MD, 78, Independence, died February 13, 1997. Dr. Link received his bachelor of science degree and his medical degree from the University of Nebraska. He completed his internship at the University Hospital in Omaha and was in private practice in Independence from 1943 to 1990, except when serving in the U.S. Air Force from 1953 to 1955. Dr. Link served as President and member of the Board of Directors of the medical staff of the Independence Sanitarium and Hospital. He was also a member of the Executive Committee of the Jackson County Medical Society. Dr. Link volunteered as a preceptor to University of Missouri medical students and was a clinical assistant professor of medicine until retiring in 1990. He was a medical instructor at the Independence Sanitarium and Hospital School of Nursing. Dr. Link was a Diplomate of the American Board of Family Practice and served as Medical Director of Resthaven Nursing Home. He was a member of the Missouri State Medical Association.

Clyde L. Brower, MD, 81, Independence, died February 15, 1997. He graduated from William Jewell College with degrees in chemistry and mathematics and earned his medical degree from the University of Kansas School of Medicine in 1944. In World War II, he served as a Medical Officer aboard a U.S. Naval destroyer. Following a surgical residency in Little Rock, Ark., Dr. Brower was in private practice in Duarte, Cal., In 1973, he relocated to Independence and practiced general medicine until his retirement in 1984. Dr. Brower was a member of the Missouri State Medical Association.

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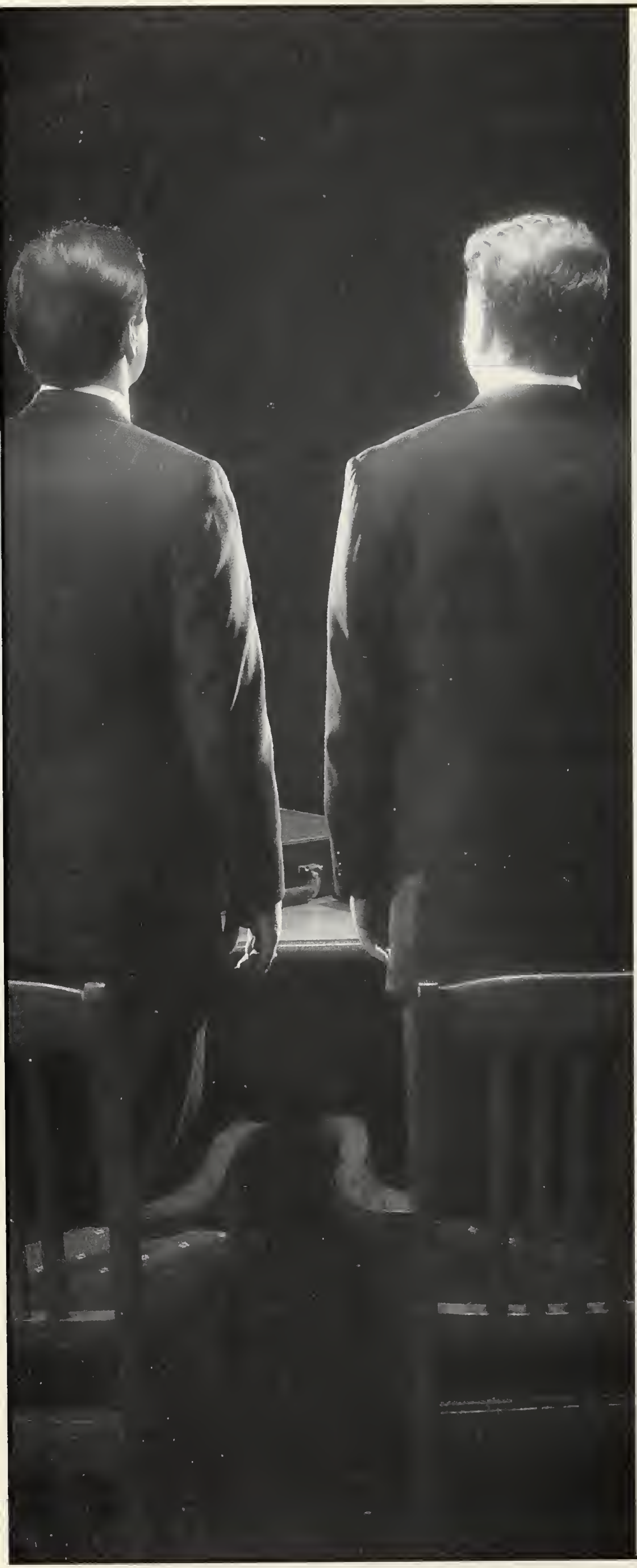

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"React, Not Over-React"

J. Regan Thomas, MD, Editor

The public, at least as reflected by the media, seems to have a tendency to over-react to "side effects." Some might say that because of the media, the public may be over-reacting. A recent case in point centers on air bags in automobiles.

The initial concern followed disclosure of several deaths in children related to air bags. Recent reports by the Associated Press stated that air bags have been blamed in the deaths of 38 children (as well as 24 adults). That publicity has begun a flurry of regulatory proposals that allow removal or disconnection of air bags as well as possible purchase of new autos without the air bag feature.

Now several new studies point out potential air bag dangers. A University of Michigan study shows that nearly two-thirds of drivers in auto accidents of air bag equipped cars sustained some type of injury from the mechanism. The researchers reviewed 540 auto accidents. About 3% of the drivers sustained broken bones in the forearm or hand. These fractures were caused by the deployed air bag banging the driver's arms and hands into the windshield or instrument panel. Two percent suffered eye injury. Of that 2%, nearly all recovered without long-term effects. Another report from the UCLA ophthalmology trauma center described five air bag injuries to eyes.

What is often overlooked unfortunately, is how many injuries are prevented by air bags. How many lives are saved by air bags? Government estimates are that at least 1,700 lives have been saved by air bag technology.

What is often overlooked unfortunately, is how many injuries are prevented by air bags.

A more logical approach, it would seem, is to refine and redesign air bag technology, not eliminate air bags. The media and the public must realize that even though a small percent of crash victims are injured by air bags, many more individuals benefit from them. Remember that most of the injuries are minor. The tragic deaths are largely eliminated by having children in the back seat with proper seat belt usage. Change the design and velocity of air bags, but don't forget that most people are not injured. In fact, many more people are saved rather than injured. To do otherwise, fails to evaluate the data realistically. It is an over-reaction to the situation.

Similar examples come to mind. Parents who fail to immunize their children due to the fear of side effects and from reports of deaths or severe post-immunization injury. What does not always get reported or remembered are the comparatively huge numbers of children who are saved due to immunization programs.

The media should take the responsibility to avoid sensationalizing information of this type. A balanced report including accurate assessment of the relative impact of the positive benefits of the issue should be presented. As physicians, we should be ready to inform our patients of both sides of these situations and put the information in perspective. The goal should be to act or react, but not over-react. MoMed

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Working to be Relevant

A.J. Campbell, MD, MSMA President

One of the things I hope to do in this column over the next year is to address ways in which MSMA is working to be relevant to the real world needs of today's physicians. A brief overview of some of our activities underscores the dynamic and evolving nature of our Association: the fine work already done and continuing forward to establish a statewide MSO for the benefit of practicing physicians; the educational and practice management functions which we continue to sponsor; the information networking which we are developing to keep our membership current with the clinical and political information so vital to our functioning as effective health care providers for our patients; and the outreach and social functions through which we hope to foster a sense of camaraderie and open exchange among physicians in our state.

For the MSMA to address such a broad palate of concerns requires not only the excellent support staff which we are so fortunate to have in Jefferson City, but in an even more vital way, a commitment to participation and growth by our members.

An organization can grow in two ways. One is to achieve a greater level of participation among our existing membership. Each of us is overextended and "too busy" in our professional and family lives, yet each of us has benefited from the work done by the MSMA on our behalf. As the MSMA grows, I challenge each of you to choose one area of the Association's activities that really interests you and make a contribution in that arena. Some of us are motivated and interested in issues related to the MSO and practice management issues: see where you can get involved and help out! Others are computer "buffs" who really enjoy not only being "on-line," but who could also help work out the most effective and accessible means by which to bring information to our members across the state. Still others have other interests and aptitudes which could be of major benefit to the organization. Each of us has an area in which we'd like to see the MSMA grow, and areas in which we have some expertise to contribute. Let's accept these challenges to do what we can to make ours a model state medical association!

> **The more you participate in the MSMA, the stronger, more satisfying, and ever more relevant we will become.**

The second way MSMA can grow is to add new members, who represent not only larger numbers, but even more varied interests, concerns, and talents. As we, ourselves, contribute to the organization, we make it a more vital and attractive organization to others. Similarly, as we encourage new members to join, we add to the vitality and diversity of our organization.

I urge each of you this year, first, to contribute to our Association in ways which you feel will help it (and you) grow, and secondly, to reach at least one other person with the message of membership in this fine organization. The more you participate in the MSMA, the stronger, more satisfying, and ever more relevant we will become. **MoMed**

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Organ Donor Card Use By Trauma and Transplant Center Personnel

Marc J. Shapiro, MD, FACS, FCCM
Mary Keegan, RN, MSN
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Introduction

The field of transplantation has advanced leaps and bounds over the past 40 years with the advent of increased technology, expanded knowledge in immunosuppressive therapy, and increased advances in methods of preservation. There remains, however, a serious shortage of organs available for transplantation. In November 1996, there were 49,223 patients in the United States waiting for organs, but in 1995, only 5,360 organ donors were able to be utilized.[1,2,3] More than 60,000 people die annually or are maintained on suboptimal therapy who potentially could benefit from kidney, heart, liver, heart-lung, pancreas or lung transplantation.[3] A review of 32,562 deaths in a region of Kentucky with a population of 3.4 million revealed 173 potential solid organ donors. However, there were only 38 solid organ donors utilized from this potential pool.[4]

Historically, government policies regarding organ and tissue procurement in the United States have been based upon volunteerism and altruism. The Uniform Anatomical Gift Act enacted in 1968 gave rise to the now present donor card in an attempt to obtain more organs and to ensure that organ and tissue procurement occurs on the basis of the voluntary choice of the deceased or his/her family. By 1973, all 50 states and the District of Columbia had adopted some form of the Uniform Anatomical Gift Act. Almost 25 years later the need for vital organs continues to increase yet the supply of potential donors remains constant.

Section 2E of the Uniform Anatomical Gift Act states, “the rights of the donor created by the gift are paramount to the rights of others except as provided by Section 7(d) (medical examiner’s duties).” With proper documentation, such as the signed back of a driver’s license, or a signed donor card, hospitals can legally remove organs from patients who have died even if the families object. However, this does not take place as the majority of hospitals throughout the United States require written family consent at the time of donation. Three major reasons which are given for requiring family consent are: 1) to avoid possible legal disputes; 2) ethical considerations, and; 3) bad publicity.[5] Therefore, a primary potential benefit of the Uniform Anatomical Gift Act, to increase the supply of new organ donors, has not been realized.

The National Organ Transplant Act of 1984 (PL 98-507) prohibits the sale of organs and tissues for the purposes of interstate commerce. This act attempts to encourage altruism and volunteerism by requiring each hospital receiving reimbursement from Medicare in the United States to offer the opportunity for families to donate organs and tissues whenever a death occurs.[6] Between 1985 and 1990, 44 states enacted legislation referred to as “required request” or routine inquiry laws. These laws held hospital administrators responsible for making sure that families are approached at the time of the patient’s death about the possibility of organ and tissue donation. The supply of vital organs has not increased, however tissue donations have increased with the enactment of these required request laws.[7]

Approximately 10 years ago a nationally representative telephone survey found that 94% of the population had heard or read

Continued on page 206

about organ and tissue transplantation. Half of those aware of organ transplantation said they were likely to want their own organs donated after death. Fifty eight percent of those said they would honor the request of a relative's willingness to donate as denoted by a signed donor card; however only one in five (19%) of those aware of organ donation and transplantation had actually completed and signed an organ donor card.[8] In an effort to look at the relationship between the belief in organ donation and the willingness to donate at a University Level I Trauma and Transplantation Center, a prospective study was conducted to assess the belief in donation with signing of an organ donor card by hospital personnel.

Materials and Methods

The Divisions of Trauma Services and Transplant Services of St. Louis University Medical Center monitored seven parking lots and structures in which St. Louis University Hospital health care workers park. The review was done from 5:30 a.m. through 8:30 a.m. on a spring Wednesday morning. This survey was completed as part of the activities planned by the University for Organ Donor Awareness Week. There was no advanced advertisement of this survey, nor any organ donor awareness activities planned other than the usual activities held throughout the year. All vehicles entering the lots were stopped and the drivers and passengers (all employees) were asked whether or not they believed in organ donation and whether or not the back of their driver's license was signed. Participants of the cars were given brochures on organ donation and perks, such as shoestrings, ball point pens and pins in order to increase the awareness of organ donation. Participants who had signed the back of their organ donor card, whether or not they believed in donations, received a complimentary breakfast muffin, in addition to the organ donation materials. A student T-test and Chi square analysis were used when appropriate with significance at $p \leq .05$.

Results

Four hundred and thirty-two employees were surveyed. One hundred and fifteen (26.6%) were male and 317 (73.4%) were female. Seventy-three percent (315) stated that they believed in organ and tissue donations, and 27% (117) stated that they did not believe in it. Forty-two percent (180) stated that they had signed an organ donor card or the back of their driver's license. There was no significant difference between sexes in their belief of organ donation and in whether or not their organ donor cards were signed. Two hundred and thirty-six (74%) females stated they believed in organ donation and 81 (26%) did not. Seventy-nine (69%) males believed in organ donation and 36 (31%) did not. Forty-four percent (139) of the females surveyed did have a donor card signed, while 56% (178) did not, and 34% (39) of the males had their cards signed, while 66% (76) did not. Of those 315 who said they believed in organ donation, 178 (57%) had signed their donor cards, and 137 (43%) had not signed their donor cards. There was a significant difference in those who stated that they believed in organ donation and those who had signed their organ donor cards ($p \leq .05$). Therefore, not everyone who believes in organ donation signs their organ donor card.

Discussion

The first kidney transplant was performed in 1954 between identical twins. Since that time many advances in transplantation have taken place. One area which continues to suffer and not improve is the attempt to increase supply of vital organ and tissue donors. Legislation has not improved the need for vital organ donations. Government required request law compliance has been reported to be low with reports as few as 10% of hospitals making requests or assuring that families knew about their rights to donate organs and tissue.[6] Despite a high level of public awareness about organ donation, there is still a paucity of people who actually sign the back of their donor cards. Horton et. al. reports that only 14% to 19% of people actually sign their donor cards.[9] In part this is due to public misconception such as the belief that a valid donor card must be on file with the United States Government in order for a donation to take place upon their death.

The primary motivation for signing an organ donor card is to help someone else even though donors in general have difficulty discussing these issues. Many reasons have been given as to why one would not sign his/her donor card. Up to one-third of people polled were opposed and about two-thirds were ambivalent or simply had not considered the question. The major reasons were hastiness of organ removal, mutilation of the body, a fatalistic view of preparation for their own death, religion, age, and some respondents stated that they had just never thought about it. [10]

Psychologists have searched for strategies to address the issue of willingness to sign the donor card: one is investigating methods of influencing people to donate and the other is exploring differences between donors and non-donors. Robbins looked at personality factors related to organ donor card signing and found that non-donors had higher death and anxiety scores with donors having more acceptance of dying, perhaps identifying a target group for donation.[11]

Simmons et. al. found donors to be less traditional, more likely to relate to religion in a non-conventional or non-traditional manner, to attend church less frequently, and to see religious values as congruent with science.[12]

Our study population consisted of health care workers at a Level I Trauma/Transplant Center in St. Louis. This center provides about one-quarter of the vital organ donors for this region. This center also is very active in the area of transplantation, in that all vital organs and tissues are transplanted. It is disheartening to see that only 73% of those surveyed believed in organ donation and that only 43% had their cards signed. Further study is needed in order to look at relationships between health care workers overall and health care workers working in a trauma/transplant center, their belief in organ donation, and their willingness to sign an organ donor card.

The findings at our facility led to the development of a program to provide exposure to our personnel on the benefits of transplantation in an attempt to have cards appropriately signed for those who believe in transplantation. This is most likely a goal that needs to be addressed at all United States health care facilities, especially those that don't have transplant programs. Only by promoting organ donor awareness among the health care community will the number of donors from the general population increase. Transplants do save lives, and therefore this is an area of concentration that is much needed in order to try to increase the donor organ pool. MoMed

The Authors

Dr. Marc J. Shapiro is Director of the Trauma Center at St. Louis University. Mary Keegan and William Luchtefeld are Trauma Nurse Coordinators at St. Louis University. The authors wish to thank members of Trauma Services and Transplant Services at St. Louis University for their assistance.

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Report from Senegal
Giant Spiders

Donald G. Sessions, MD

One morning, one dawn of a morning, I was on my way to the office - walking the same route, only this time I was on the streets quite a bit earlier than usual. It was still rather dark, and being dark and early, there was a feeling of eeriness - it was not unpleasant. I turned onto a street that was on a hill and the side I turned onto went up, eastward. Walking in Dakar when there is hardly any traffic can be rather surprising.

Some movements caught my eye and I looked up to the top of the hill. Silhouetted against the eastern sky were three giant spiders inching themselves across the street in a single file: they seemed to be about three feet high. I was stunned but not afraid. As I got closer to them, I saw that they were three creatures walking on their hands and knees, elbows and ankles, wrists and whatever. I looked at them; they did not look at me. What happened then is what always happens to me when I see naked misery. A huge, heavy sadness hits me in the chest and stops me cold. I think about how far we (they) have to go, and for how long before a dent is made, and for how much, and who will do it.

And what can I do - I cannot make a dent, can I?

Sure I can - but will I?

Will I?

Now, at my age, my attention is turning to gardening, a little helping here, a little helping there, traveling, and the like. Can you picture me trying to tackle a monumental project like a clinic for these poor babies, these poor spiders? Maybe you can see that for me. Honestly, I can't.

But . . .

Dorothy J. Nash
Dakar, Senegal
Summer, 1996

I met Dorothy Nash when I entered my residency in Otolaryngology at Barnes Hospital in 1965. At that time, she was an audiometrist conducting hearing tests for Dr. Theo Walsh, our Chairman at Washington University Medical School. Dr. Walsh was a stickler for detail and committed to having his patients tested with the utmost skill. Dorothy was more than up to the task and produced for Dr. Walsh in the same successful manner she utilized to raise her children as a single parent. She never used excuses - she just got the job done.

Subsequently, Dorothy Nash became our office manager and when the time came, she retired. It did not surprise me, however, when I learned that in her retirement she had volunteered for the Peace Corps and was off to Senegal where she admitted she was living "en brusse" with no electricity, water from a well that was half a block away, and no latrine for the first six months. "What did I do?" she said. "Well the millet fields were as high as an elephant's eye."

Dorothy Nash's project was to work with the people of a rural Senegalese village named Thiafoura to create a health care clinic. She worked with the Village Association from original planning through obtaining funding, to construction, and completion. This is how she described the results in a letter to her manager in the Peace Corps Partnership Program in June 1996.

> *It is with the greatest pleasure that the Village of Thiafoura and I announce the completion of the furnishing of our Health Care Clinic.*
>
> *This structure, consisting of an office for the nurse and a treatment room, an office for the midwife and a treatment*

room, a two-bed ward, a waiting room, two bathrooms, plus 10 iron doors and screens, 10 louvered iron shutters and screens, an iron gate in a concrete wall completely surrounding the clinic - all had two coats of paint where suitable and three coats of whitewash where suitable.

The paint, whitewash, iron gate, and cement for the wall were paid for through the PCPP fund (685-056). By the same token, all of the equipment came by way of this same fund. Receipts available upon request.

ALL furnishings and supplies were NEW.

The clinic uses the Bameko Initiative method of cash flow. Patients are charged for visits, treatments, medications, births, etc. The money is proportioned and set aside in a certain amount for medical supplies, a certain amount for salaries for the nurse and midwife, plus a certain amount for minor expenses. Also, there is in reserve 100,000CFA; a maintenance fund. This money was raised by the villagers in September of 1995 - they had a lottery. The clinical business and financial business is overseen by the Village Association - with periodic visits from Dr. Bireme Fall, the regional Chief of Medicine.

The clinic has been busy from the time it opened, officially December 2, 1995. Thus far there have been 30 babies born (including one set of twins). Incidentally, the numbers are even - 15 boys and 15 girls. On my last visit in May of this year, the staff was preparing to vaccinate approximately 500 children.

People connected with the Peace Corps have made several visits to this dispensary -- Peace Corps Volunteers, PCVLs, APCD Health, and our own Country Director, Patrick Barry and family, plus some members from the American Embassy. Also, frequent visits from the clergy from the Catholic Mission in Popenguine. A special thanks to the Monks there.

The cross-culture exchange is still alive and well -- there is a great deal of exchange of letters and photos and high hopes to travel to each other's country.

This has been a truly extraordinary experience for me. I do not have the slightest doubt this Health Care Unit will continue to serve Thiafoura and the surrounding villages for a long, long time and it will serve them very well.

Big, big thanks to the donors, to the Rotary Clubs, and to the Peace Corps Partnership Program. We did it as a team. The key phrase here is:

WE DID IT

and bear hugs all around.

I love Dorothy Nash. She is not just my personal Mother Teresa, she's more than that. You see, she is just Dorothy Nash from Webster Groves, who is absolutely "spirit in action." She inspires me.

Of this I am certain: her giant spiders are in good hands. MoMed

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The Staff and Serpent of Asclepius

George M. Bohigian, MD

Abstract

The Staff of Asclepius is one of the most common symbols associated with medical profession. The emblem of a single snake and a staff is a true representation of medicine in contrast to the caduceus. The origin, meaning, and evolution of the Staff of Asclepius is found in antiquity.

One of the most persistent mistakes in medical symbolism is the continued misuse of the caduceus as a symbol of medicine.[1,2] The incorrect use of the caduceus, which in Greek means “herald’s wand,” can be traced to Sir William Butts, physician to Henry VIII.[3] Butts mistakenly believed the caduceus to be the Staff of Asclepius, and thus began a tradition of misusing it as a symbol of the healing arts. To this day, the United States Army incorrectly uses this symbol for its medical corps.[4]

The Staff of Asclepius with one snake is the only true representation of medicine. The caduceus, which has twin snakes with wings, is a much later representation of the symbol of medicine, but it is not the original symbol. (See Figure 1)

According to Greek mythology, Asclepius (See Figure 2) was a son of Apollo, but he may also have been a famous physician. In Homer’s *Iliad* he is mentioned only as a physician who practiced in Thessaly, Greece around 1200 B.C. Eventually, however, he was deified and worshipped as a god. Asclepius, the Greek god of healing, used snakes in his temple and was so powerful that he could bring the dead back to life.[5] When Hades, the god of the dead, complained to Zeus that Asclepius was upsetting the order of nature by cheating the kingdom of death, Zeus struck down the healer with a thunderbolt.

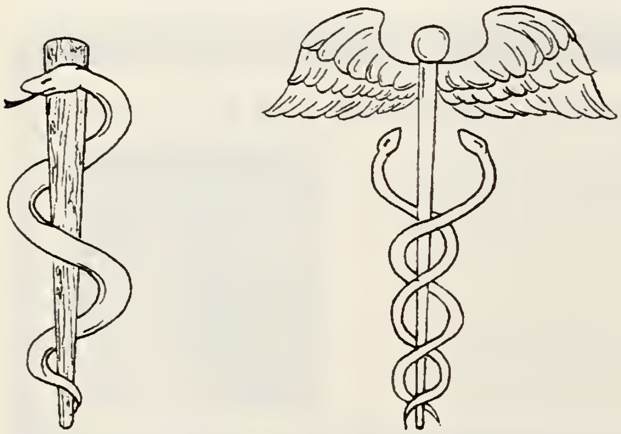

Figure 1. The serpent and Staff of Asclepius in comparison to the caduceus

The healing temples of Asclepius were found throughout ancient Greece usually in healthful, natural settings such as groves or mountains to insure restful surroundings. The sick bathed in a sanctified fountain and then prepared to sleep in the temple. The priests whispered hypnotic suggestions and incantations to help cure the patient while in a dream-like state.[6] Patients suffering from depression were put in temple healing rooms containing snakes to shock them out of their stupor.

Why does a staff and snake represent the healing arts? In antiquity, the snake was a popular symbol used to guard against evil. Egyptian hieroglyphics and Biblical writings record both the worship and hatred of snakes in accordance with various dynasties and political powers.[7] In Numbers 21:8, the Lord commands Moses to “make a fiery serpent, and set it on a pole; and everyone who is bitten, when he sees it, shall live.” The ancients looked upon the snake as a symbol of health and healing because it could shed and regenerate its skin. Linked to its close association with the earth, the serpent became preeminently the animal of the underworld and the realm of the dead.[8]

The caduceus is incorrectly used as a symbol of medicine. This staff of olive wood with a pair of wings topped with a pine cone and a pair of snakes coiled around the staff is the staff of Hermes (Greek) or Mercury (Roman), the messenger of the gods. According to mythology, Mercury carried this herald’s wand to protect himself from Juno’s evil eye. Similar staffs were carried by travelers in ancient times to protect themselves from interference.[3] The staff frequently depicted as a branch of a tree, symbolized the mystery of plant growth and the

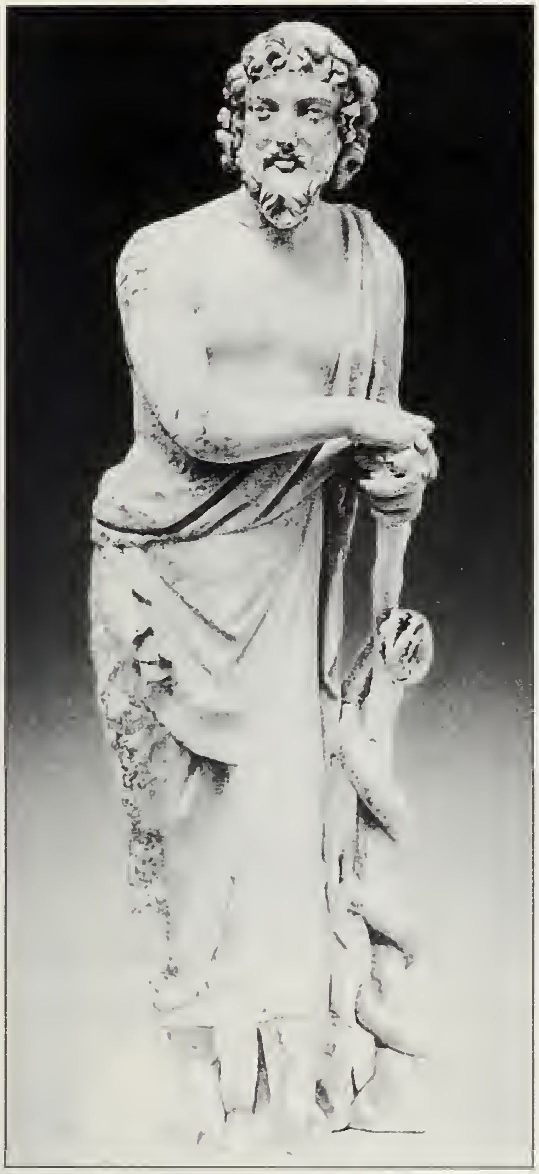

Figure 2. Asclepius, the Greek god of medicine (Rhodes Museum)

indestructible vitality of the earth. The continued popularity of the caduceus today can probably be attributed to its being more aesthetically appealing than the staff of Asclepius.[1] The symmetry of the wings atop the staff and double snakes is more balanced than the staff and single snake of Asclepius.

The snake and the staff have become literally entwined and united as the symbol of medicine and life of the earth. From the time Eve encountered the serpent in the Book of Genesis until an angel used his golden chains to bind the serpent (representing the devil) for a thousand years in the Book of Revelation, the ever-present snake has been a force to be reckoned with.[9]

The Staff of Asclepius is the proper symbol of medicine and is used today as the emblem of the American Association of Medicine. We should be aware of the historical and mythological background of this image and use it properly and with pride.

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Radiology Quiz #12

Roger A. Francis, MD
Radiology Department, Lake of the Ozarks General Hospital

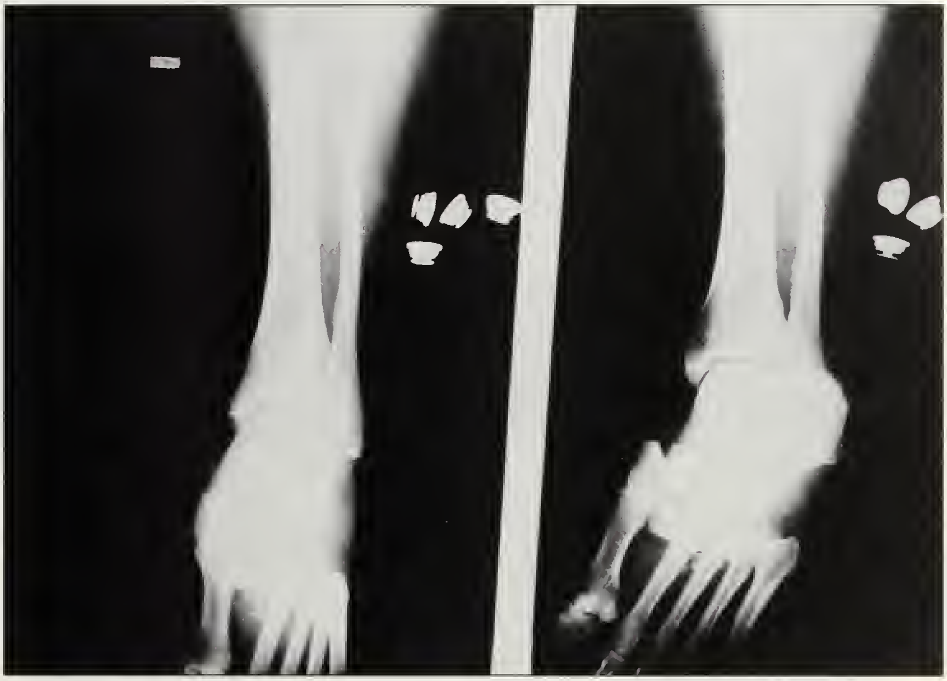

Figure 1

A 35-year-old female was brought to the emergency room after an auto accident. You are shown A.P. and internal oblique views of the left foot and ankle (Figure 1). What is the most likely diagnosis?

What is the diagnosis?

a. **Lisfranc fracture-dislocation**
b. **Chopart's dislocation**
c. **trimalleolar fracture-dislocation**
d. **subtalar dislocation**

(See answer on next page.)

Specialty Quiz Answer

The Radiology Quiz question is located on the previous page.

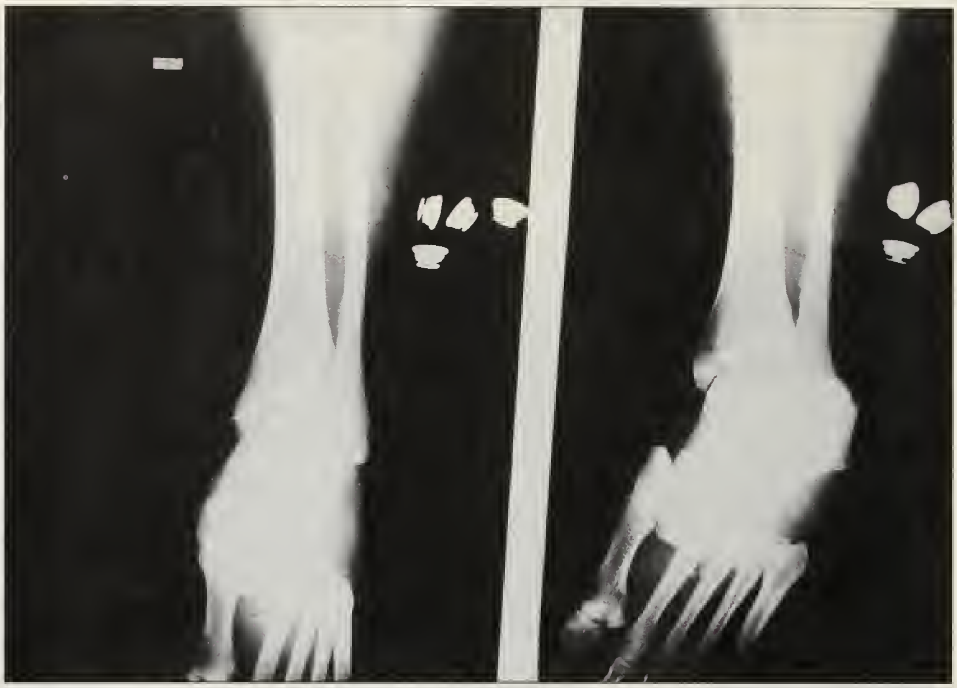

Figure 1 repeated

ANSWER: a. Lisfranc fracture-dislocation

Radiographs show lateral and dorsal dislocation of the left 2nd through 5th metatarsals (arrowheads). There is medial dislocation of the medial cuneiform and 1st metatarsal (arrow). There are several small fracture fragments about the metatarsal bases. The above findings indicate injury predominantly at the level of the tarsometatarsal joints, termed the Lisfranc fracture-dislocation. The ankle (tibio-fibula-talar) joint and midtarsal (talo-navicular and calcaneo-cuboid) joints of Chopart all appear intact.

The Lisfranc injury, or dislocation of the tarsometatarsal joints, may result from a variety of trauma mechanisms which result in disruption of the normal stabilizing ligaments about the tarsometatarsal joints as well as the joint between the 2nd metatarsal base and the recessed middle cuneiform. There are two types of Lisfranc injury. The homolateral type occurs when the metatarsals dislocate in the same direction, usually laterally. The divergent type occurs when the 1st metatarsal dislocates medially and the remainder of the metatarsals dislocate laterally. The test case is a variant of the divergent type, with the medial cuneiform dislocating medially with the 1st metatarsal. Chip fractures of the metatarsal bases, cuneiforms or cuboid are commonly associated with the dislocations.

Lisfranc injuries are commonly overlooked, and may be subtle. The key to diagnosis is to look for normal alignment of the metatarsals with cuneiforms and cuboid. These anatomic relationships should be searched for especially in fractures involving metatarsal bases.

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Virtues and Informed Consent

O. Gerald Orth, MD, PC

> *The slave doctor prescribes what mere experience suggests—and when he has given his orders, like a tyrant, he rushes off. But the other doctor, who is a freeman, attends and practices upon freemen—he enters into a discourse with the patient and with his friends—and he will not prescribe for him until he has first convinced him; at last, when he has brought the patient more and more under his persuasive influences and set him on the road to health, he attempts to effect a cure.*
>
> *Plato, The Laws*

Informed consent is a relatively recent concept as applied to physician-patient interaction. The concept is a reflection of societal changes that have evolved from the outgrowth of empowerment of the individual in society.

By recognizing the disadvantaged in society by passage of the Civil Rights laws in the 1960s, an unintended consequence of these laws has been the recognition of the majority of society that their selfhood was important, so much so that the pendulum has swung so far in the direction of individual rights that the person now perceives himself or herself to be apart or separate from societal organization.[1] It is in this context that informed consent is now derived.

Initially, informed consent laws were applied to experimental procedures, and the first American court case involved a surgical operation, *Mohr v. Williams* in 1905. Judge Cardozo declared in 1914 that "every human being of adult years and in sound mind has a right to determine what shall be done with his own body."[2]

The Nuremberg Code was the first formal declaration of the rights of subjects involved in experimental procedures. It involved primarily obtaining a signature of consent.

After the Second World War, courts also began to draw sharper lines between doctor-patient relations in practice and in investigator-subject research. A particular egregious case involved a Canadian student who, for a small fee, was given an experimental drug while under a general anesthetic and sustained a cardiac arrest which necessitated a thoracotomy for heart massage. Fortunately, the student survived. *Halushka v. University of Saskatchewan* led the Canadian courts to proclaim that "the subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities, and opinions which a reasonable man might expect to consider before giving his consent."[3]

In 1957, *Salgo v. Stanford*, the court proclaimed the right of the patient to all relevant facts needed to make an intelligent decision regarding proposed treatment.

Initially, the physician was only required to give information similar to what his/her fellow colleagues might provide. The reasonable physician standard was established by the Missouri Supreme Court in 1960.[4] But more recently, the courts have adopted the practice of requiring information related to what a reasonable person would require in order to make an intelligent decision regarding treatment. This was articulated by the United States Court of Appeals in 1972. Thus stated…a risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.

In Missouri, informed consent consists of informing the patient of his medical condition, the proposed treatment, treatment alternatives, treatment risks, and the likelihood of success.[5]

As late as 1979, most courts were concerned with physician disclosure and not necessarily patient understanding of the disclosure. Patients are presumed to have the capacity to comprehend the information with which they are provided to the extent that a reasonable person would understand it.

Rather than looking at

informed consent from a legalistic manner, perhaps informed consent should be viewed as two persons each practicing moral virtues to the fullest degree possible. All moral virtues are in some manner involved in the process of informed consent.

Originally, physician-patient interaction was viewed from a paternalistic viewpoint, with the implication that the physician was a virtuous person, always acting in the best interest of the patient, and attempting to treat the patient as he/she would like to be treated. The physician's ruling principle of treatment was primum non nocere.

Some would argue that "first do no harm" principle is an inadequate and incomplete as implied for physician conduct. Dr. Edward Pellegrino would like to see the values expressed in a physician-patient relationship expanded to one described in the first century A.D. by Scribonius Largus, a physician to the Emperor Claudius. He noted that the responsibilities of the physician were related to the nature of medicine itself whose end he believed was "humanitas." Roughly translated, this is described as love of mankind. He also recognized the need for mercy and hence his conception of medicine went beyond the Greek concept of mere kindness.[6]

There are generally three components to implied consent; voluntariness, disclosure of information, and competence in understanding of the information.[7]

The voluntary aspect in decision-making is often compromised by the mere fact that illness places the patient in a different reality since it is his/her health or life that is at stake. This implies a limitation on the patients freedom. A decision will have to be made for or against. This decision can be clouded by fear. It can also be influenced by the patients' acquiescence to a perceived authority figure. In fact, some physicians note that patients will, if they trust their doctor, accede to almost any request he/she would care to make.[8] This could be considered patient manipulation. For consent to be truly voluntary, the patient must be free from the influence of persuasion or threat. The thinking must not be impaired by the emotion of the situation or deliberation unduly sacrificed by time constraints.

The prudential aspects of informed consent are different when applied to the physician and the patient. For the physician, his/her deliberation will vary according to the degree of difficulty of the clinical situation. A past experience and knowledge of the clinical history of the illness will in most cases temper the attitude in presenting information to the patient. With an illness with a good prognosis and little risk, most physicians would not go into lengthy discussions regarding extensive presentation of the medical problem. This is perhaps a throwback to paternalism, or it may be nothing more than the desire not to overly burden a patient with information that would only add to the patient's fears and anxieties. In a legalistic setting, this may be considered a lack of full disclosure. It may also be represented as an infringement on patient autonomy.

A different approach, however, is taken when the treatment offered carries with it a less definite outcome and a potential for serious harm or death. In this setting, despite the physician's concerns about arousing the patient's fear and anxieties, the physician is obligated to inform. It would certainly be a violation of patient autonomy not to inform.

It is somewhat ironic that those situations that engender the most anxiety and fear for patients are the very ones that require the most information for the patient to arrive at an informed opinion. This is the down side for complete patient autonomy, in that the patient must be willing to assert his/her full responsibility for complete knowledge of his/her medical situation. But, it also recognizes the full disclosure that the patient needs in making a prudential judgment. The patient must know the facts, as unsettling as they may be, deliberate and then act.

The courage of the patient's act must also be restrained by temperance so that an overly optimistic outlook and a denial of a poor result lead to a poor judgment.

Christian theology has always insisted that when it comes to concrete ethical decisions each normal individual has the capacity and the responsibility to judge and to act on his/her judgment.[9]

The capacity to make practical judgments in matters involving ethical issues is called conscious. It is the duty of a physician to aid in informing the patient so that his/her conscious is fully informed.

Continued on page 218

Continued from page 217

There are two exceptions to the general principle of disclosure. One is in the case of an emergency when a sufficient delay in obtaining consent would result in harm for the patient. The second is identified as the therapeutic privilege. In essence, if discussion of the risks of a procedure would be so detrimental to the patient's condition, that discussion itself is contraindicated. Rarely, does therapeutic privilege apply, and it cannot be used by a physician for lack of disclosure.

Therapeutic privilege was initially stated in *Twombly v. Leach*, a Massachusetts case noted in 1853. More recently, it has been reinstated in *Wooley v. Henderson* in Maine, 1980.[10]

A recent example of conflicting interpretation regarding informed consent is illustrated in an article from the *St. Louis Post Dispatch*, describing a malpractice case where a patient experienced weakness in the movements of his foot following lumbar disk surgery.[11] The physician may or may not have informed the patient of this potential complication. It is only in believing that a perfect result is to be expected, that rare complications are now considered malpractice. If we would assume that this physician has never had this complication, what would be his obligation to inform of the risk? In a legalized system, the physician might have been prudent to cover all bases, but I would not claim that the physician did not practice prudence by not informing.

The view that a physician can never error raises the question of a double standard where society has moved gradually toward a "no fault" approach to tragic and difficult choices and yet exacts the highest standard of accountability from the medical profession.

Most medical decisions entail a good deal of imperfection regarding the effect of the decision on the future. There are instances when results are known when no treatment is offered, but this is not the usual situation. The responsibility for further knowledge resides with the patient if we are to assume an autonomous patient. The physician can present options and recommendations, but it is ultimately up to the patient to educate himself/herself regarding a prudent judgment. Unfortunately, in most instances, the patient is never able to obtain the knowledge, experience, and judgment that are on a par equal to the physician, and hence must rely on the prudent judgment (practical wisdom) of the physician in arriving at an informed consent.

According to Robert Hahn, there is a tension between the egalitarian ideal by which people treat each other with mutual respect, and the high value placed on expertise, according to which the experts dicta are regarded as beyond the capacity of their audience to evaluate. In medical encounters, patients are often complicit in denying their own capacity to know. Patients' incomprehension of physicians' "information" is notorious.[12]

It should also not be that those who autonomously choose to follow the command of others can thereby escape responsibility for their actions. A person is responsible for ceding his/her independence to another. What does affect responsibility is the interference with a person's autonomy when the person is not in a position to realize this is occurring or to do much about it if he/she does.

William Thompson would argue that informed consent is not possible under current law because psychological research has shown that people's risk assessments are strongly influenced by the form and manner in which the information is presented. Also, because the law allows physicians to exercise such an extensive degree of influence over people's decisions, those decisions are rarely totally free. Unfortunately, or fortunately, this line of thinking opens up related fields of study as concerns how one learns and uses the information learned, learning under psychological stress, and decision making when faced with uncertainty. At best, our judgments can never be based on absolute certitude. We will have to again consider Aristotle in that the more one enters into the depths of a decision, the more one is open to error. The patient should expect to receive knowledge about a proposed therapy, its risks and benefits and other alternatives before giving his/her consent. Because of the variability in which facts are presented to patients, perhaps what society should be stressing is the selection of people of virtue for medical students rather than relying on ethics courses for medical students. It is interesting to note the increased number of ethics courses being taught today compared to previous years.

If the present legalistic trend continues, I can envision patients receiving from their physicians, checklists of enormous size, listing complications of medicine and proposed surgery. Is this legalization to the abstruse or just a respect for patient autonomy? It is certainly not the art of medical practice or the mutual sharing in achieving the health the patient desires.

It is also in contraposition to the statement in the President's Commission for the Study of Ethical Problems in Medicine, which states that a physician invites the patient to participate in a dialogue in which the professional seeks to help the patient understand the medical situation and available courses of action, and the patient conveys his/her concerns and wishes. This does not involve a mechanical resuscitation of abstruse medical information, but should include disclosures that give the patient an understanding of his/her condition and appreciation of its consequences.[13] An interesting survey in 1982 reported that the public felt that the primary responsibility for patient information lies with the physician, 66%, primarily the obligation of the patient, 20%, and equal responsibility between physician and patient, 12%.[14]

Interesting, is the finding of a reverse relationship as concerns responsibility for being informed. Persons who did not graduate from high school felt it was their responsibility, 26%, as compared to college graduates, 15%. Likewise, minorities, 31%, as compared to whites, 18%, felt it was their duty to obtain information in order to make an informed opinion.[15]

The legalistic approach to informed consent does not capture the intended meaning of the word consent. The word consent is derived from Latin con and sentire, meaning both to know and feel together. It implies a mutual working out together of a decision. What a wonderful concept to be brothers in sharing a decision. For the patient it is this fortifying principle that augments his/her courage; knowing that he/she is not alone in the time of need. For a physician, it can present an opportunity to demonstrate "humanitis." This nature of consent demonstrates how cold the present legalistic concept of consent is where two parties are conceived as entering into a legal contract for obtaining and supplying health care.

Whereas in the past, medical practice perceived prudence as a major virtue, justice is now almost surpassing prudence as a virtue to be regarded as foremost, with prudence as a necessary preliminary in the deliverance of justice.

Medical care is now thought of as a contract. The patient is now a client and a consumer of health care. Every attempt is now required to place the patient on equal footing with the supplier of the service requested, and in some instances demanded by the consumer. This over-emphasis on rights regarding medical care has placed physicians and society in an unworkable environment as concerns developing an all-encompassing health care system.

Recently, my 92-year-old uncle was admitted to a tertiary hospital. He had incurred a cerebral hemorrhage and as a result was in a coma. Despite the fact that he had signed an advanced directive in case of such an occurrence, he continued to receive aggressive therapy. His chances for a meaningful life were very remote. His case illustrates the difficulty of limiting care if one does not recognize that all life is eventually limited and that mere existence, sustaining of the individual unengaged self, is not the purpose of life. Relatively speaking, his case should not raise questions about proper treatment.

In terms of distributive justice, he should have little claim to society goods. Unfortunately, as E.J. and L.L. Emanuel note, non-treatment of similar patients results in very little savings as concerns total cost of health care.[16]

Unfortunately, in order to effect real savings, beneficial procedures will have to be limited. Since informed consent requires information regarding alternative treatment, it is hardly ethical to withhold information regarding the benefit of coronary artery bypass surgery for the elderly.[17] The question then becomes; do elderly have the right to demand of society care that will have only marginal benefit as relates to time frame and benefit for society? Would a prudent person choose such an option if the responsibility (i.e., expense) were to be borne by his individual self? Might he/she not elect to see his/her savings go to the benefit of the grandchildren? The debate whether society has an obligation to provide technological procedures to the very elderly in society has not been engaged. There are only a few individuals in public life that have had the courage of Richard

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Lamb or Daniel Callahan in calling for discussion of these highly emotionally charged issues. Unfortunately, in a social environment that stresses individual rights and little responsibility, politicians have been reluctant to address how individuals must share in a broader vision of society and at appropriate times limit their demands on society.

Likewise, when applied to health care, statements by religious leaders that those that are most vulnerable and in greatest need can place special demands on society are erroneously interpreted that there can be no limit or end to treatment. Certainly, when applied to health care, those procedures which carry the least benefit in both human and economical terms are those at the very beginning and end of life. As recently noted in the *New England Journal of Medicine*, the extension of years for the elderly in the United States far surpasses those countries that have developed universal health care systems.[18] All universal systems ration care.

The emphasis on patient autonomy and the legalistic interpretation of medicine also changes the character from that of a profession to that of a business. Not only are moral virtues downgraded, but also the greatest virtue of all, namely charity, is greatly undermined. To quote Richard McCormick, "When, however crucial, the encounter of a physician with patient is displaced into a business context," not only is the professional ethos 'compassion, honesty, self-denial, generosity' exposed to erosion, but we all will be deprived of a transforming affect of faith alive in a physician."[19] **MoMed**

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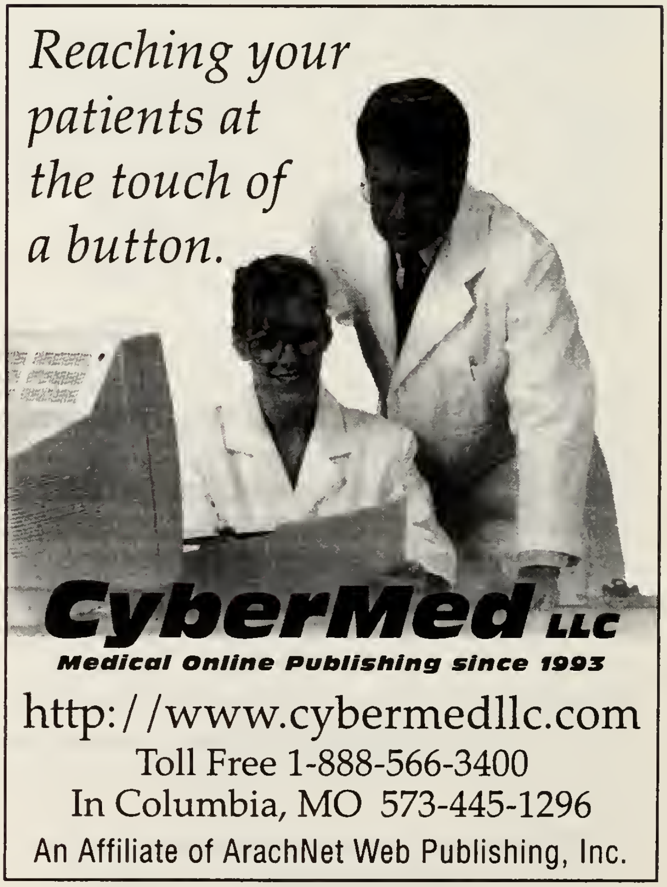

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Visionary Foundation Assists Students in Need

Patrick J. Mills, MBA, CPA
Executive Director, MSMF

Today's medical school students are facing significant decisions before they ever begin practice. Most are constantly scrambling to arrange their scholarships, loans, and grants to afford to be a full-time student. Financial need as assessed by university financial aid officers frequently exceeds $25,000 per year.

Doug Westhoff, MD, of Jefferson City, remembers, "In 1961, I was newly married, had a child, and there was no other assistance available."

The Missouri State Medical Foundation was created in 1960 by the Missouri State Medical Association and initially financed through a ten dollar assessment per member per year. This assessment ran for twenty-seven years, from 1961 to 1987. Substantial funds were also received courtesy of the MSMA Auxiliary, now Alliance, which raised thousands of dollars to assist in the funding of medical education. Additional donations are received as memorial donations for deceased members of MSMA.

"The several hundred dollars I borrowed in 1962 is nothing compared to today's numbers. There was no federal loan program and most families had to help with the tuition," said Bill Shell, MD, of Sikeston. "At the time, we were not allowed to work while in medical school."

The escalating cost of medical school has been addressed by the Foundation's Board of Trustees which has increased the maximum amount loaned per student per year from $2,000 to $4,000 in 1991 and to $5,000 in 1996.

"The Missouri State Medical Foundation has bailed out many students with loans which were easy to obtain and at a reasonable interest rate," said Marilyn McGuyre, Director of Student Affairs at the University of Missouri - Kansas City.

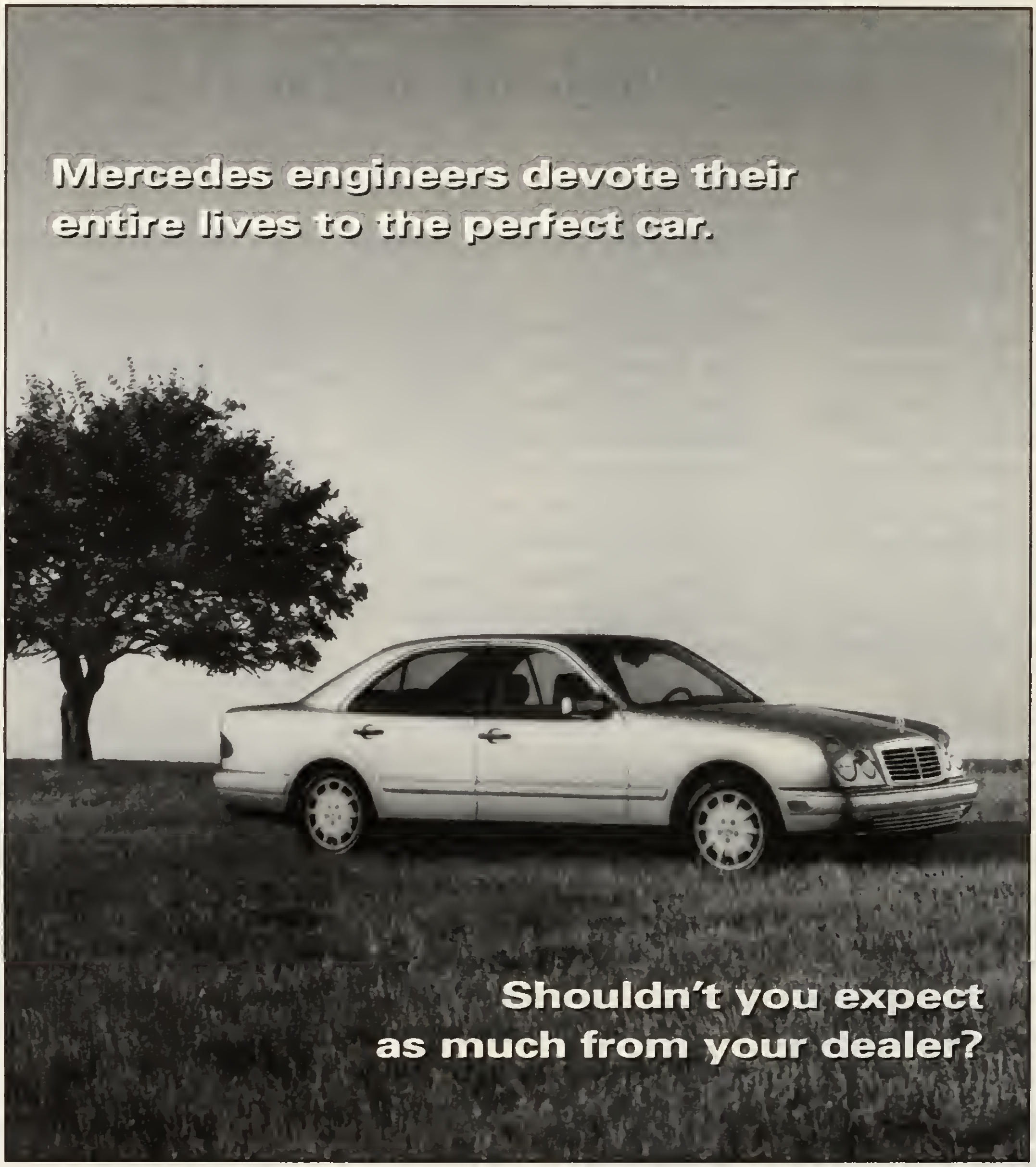
All borrowers must be Missouri residents and have first completed one year of medical school. The loan has a 4% interest rate until medical school graduation followed by a 10% interest rate. No payments are due until after medical school graduation, at which point payments are made on interest only. After residency or five years, whichever comes first, a monthly payment is worked out which will pay off the principal in five years.

While most of a new physician's debt payments are being made on federally insured loans with strict repayment schedules, the Foundation works to ensure the monthly payment being requested does not require living paycheck to paycheck or carrying substantial amounts of credit card debt.

"The main difference with a Foundation loan is in the communication," said recent borrower Jennifer Page, MD, of St. Louis. "Other loans are frequently sold by loan servicing companies."

The real payback for organized medicine comes through the allegiance many feel for the assistance which was made available when they needed it most. Several of the student borrowers have become active participants in MSMA.

In the 1990s alone, more than two million dollars has been loaned. The Foundation is prepared to continue its thirty-seven year record of success which includes more than five million dollars of loans made to Missouri medical school students with a 99% payback rate. Loan information can be obtained from medical school financial aid officers. MoMed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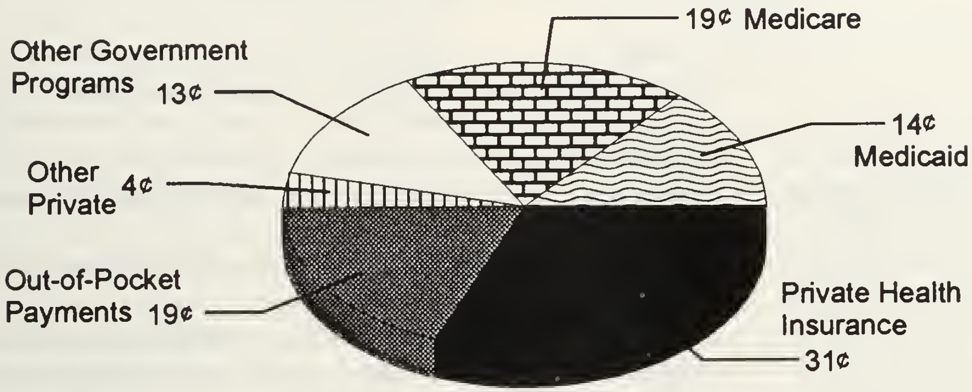

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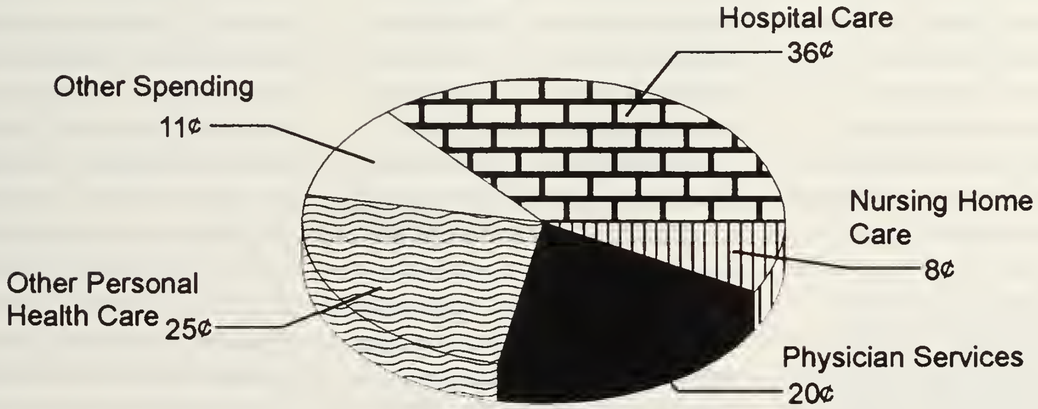

NOTES: Other private includes industrial inplant health services, non-patient revenues, and privately financed construction. Other personal health care includes dental services, other professional services, home health care, drugs and other non-durable medical products, vision products and other durable medical products, and other miscellaneous health care services. Other spending covers program administration and the net cost of private health insurance, government public health, and research and construction.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Covenants Not to Compete: A Trap for Missouri Physicians

Katharine C. Rathbun, MD, MPH
Edward P. Richards, JD, MPH

Introduction

A covenant not to compete is an agreement that if a physician leaves a practice, he/she will not set up a practice in competition with the existing practice. These restrictions have three parts: 1) what kind of medical practice is prohibited; 2) how long is the physician prohibited from practicing; and 3) the geographical limitations of the restriction. In Missouri, a typical covenant not to compete might prohibit a physician from doing family practice for three years for a radius of 100 miles from any clinic run by his employer.

Covenants to not compete limit patient's right to choose a physician, limit a physician's right to practice the profession, and increase the cost of health care by reducing competition. They are banned or severely restricted in almost every state but Missouri. It is time for Missouri to reconsider the health policy implications of covenants to not compete and to ban them from physician contracts.

Changes in Physician Employment

Traditionally, medical practices were partnerships of a small number of physicians. Before a new physician was admitted to the partnership, the physician would be expected to work with the partners for a few years. This was a reasonable precaution for both the new physician and the partnership. Since each would be responsible for the others debts and business obligations, this trial period assured that everyone was comfortable before entering into the legal entanglements of a partnership. The new physician would sign a covenant to not compete to protect the existing practice. A typical agreement might prevent the new physician from setting up a new practice within two miles of the existing practice for six months or a year.

Now, rather than being in a small partnership, most physicians are members of large groups or employees of medical services corporations. For most physicians now entering practice, the only work available is as an employee, and existing partnerships are under pressure to merge or be acquired by hospitals or insurers. Covenants not to compete can be used as weapons to force physician employees to act against their patients interests, or be forced from medical practice. Physicians signing these agreements must understand their ramifications, and that Missouri courts will enforce them.

Special Problems for Missouri

Missouri is almost alone among the states in treating medicine no differently from other service industries. In the early 1900s, a Missouri court held that any corporation may employ physicians to deliver medical services.[1] Other states prohibit the direct employment of physicians by non-physician corporations. This is called the corporate practice of medicine, and is prohibited in most states because it allows a non-physician employer to tell a physician how to practice medicine. For example, in states other than Missouri, a hospital must contract with an independent physician-controlled corporation or directly with individual physicians to provide its medical services. In Missouri, the hospital can employ the physicians directly.

Until recently, few corporations took advantage of the ability to hire physicians directly. This is changing rapidly and many physicians are finding themselves working for nurses, administrators, or accountants. Since these supervisors can hire and fire physicians, they can use this power to dictate the medical care the physicians will provide. The physician's only recourse when faced with a demand to provide improper medical care may be to quit. Unfortunately, if the physician's employment contract contains a strong covenant not to compete, the physician will have to leave the community to find other work, and often will have to leave Missouri entirely. Few physicians can afford to lose their job and uproot their home and family.

Physicians in states that bar the corporate practice of medicine may still face improper coercion. Physician employers and physician corporations are also susceptible to pressures to reduce costs in ways that reduce the quality of care. Most states recognize this and provide additional protections for the physician-patient relationship. As one Ohio court stated, "when an ailing person selects a physician to treat him, he does so with the full expectation that such physician will do his best to restore him to health, and the contract into which they enter is deserving of more attention from the law than a businessman's expectation of profit from a purely commercial transaction."[2] These states either ban the use of covenants to not compete in physician employment contracts,[3] or greatly restrict the circumstances when they will be enforced.

In general, Missouri courts have been much more concerned with the rights of employers to prevent competition by former employees than they are with the public's right to choose service providers, or with reducing the cost of services through encouraging competition. Missouri enforces covenants to not compete with more onerous terms than most other states. The situation is much worse for physicians in Missouri than in other states. Unlike other states, Missouri courts have put no restrictions on the use of covenants to not compete in physician contracts. This is a surprise for many lawyers advising physicians about contracts. Unless they have looked specifically at Missouri law, they assume that Missouri is like other states and will not enforce very restrictive covenants to not compete. The result has been a mythology among physicians that they can sign these agreements and then beat them in court. In most cases the physicians lose, and have to pay tens of thousands of dollars in legal fees as well. Even when the court refuses to enforce the covenant to not compete, the physician is very seldom awarded attorneys fees.

What is the Impact on Physicians and Patients?

Other states have banned or limited covenants to not compete in physician contracts because of the impact on patient care, patient choice, and economics. The worst problems arise in smaller medical communities where there is only one physician providing a particular type of specialty care. If the town's only gerontologist cannot leave the local physician services corporation and still stay in the community, then the physician's patients may no longer be able to receive that specialty care in the community. The more common problems arise with patients who have chronic conditions, or are undergoing individualized long-term treatments. While other physicians may have the necessary expertise, they will not have the benefit of the special knowledge of the evolution of the patient's condition over time.

Even in situations that do not involve complex continuing care, most patients would prefer to be able to choose their physicians, at least within the constraints of their insurance plans. This freedom of choice can reduce the cost of health care by increasing the competition in a community. Most importantly, it protects the physician-patient relationship. In a system where physicians must protect patients from overly aggressive cost cutting and threats to quality of medical care, the law should do everything possible to protect the physician's ability to exercise independent medical judgment. Most states have banned the corporate practice of medicine and limited or abolished covenants to not compete for physicians because they wanted to protect the physician's ability to exercise independent medical judgment. These states recognize that few physicians will risk potential financial ruin by opposing their employers. In Missouri, where these protections are not available, health plans have too much control over the physician-patient relationship and the medical care provided.

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Physicians entering practice now can expect to be employees for the rest of their careers. They have no bargaining power to refuse to sign contracts with covenants to not compete. Physicians whose partnerships sell out to a hospital or health plan usually find they are now covered by these covenants to not compete, and will probably never be in private practice again. While some physicians who are owners of groups or plans may benefit financially from covenants to not compete, they do so at the expense of patients and other physicians.

Other Professions in Missouri

From the perspective of the special relationship between the client and the professional, law is the profession that is most like medicine. Both attorneys and physicians have a fiduciary relationship with their client. The professional must not use his or her superior knowledge to take advantage of the client, and the client is entitled to be informed of the professional's conflicts of interest. More importantly, the professional must avoid conflicts of interest that will significantly affect the rights of the client. Fundamentally, because these professional relationships are built on trust, people care who their doctor or lawyer is.

Missouri recognizes the importance of this professional relationship for lawyers. Covenants to not compete were prohibited for lawyers by the Missouri Supreme Court in its role as licensing board for lawyers. The Missouri Supreme Court adopted the following rule of practice for lawyers (Supreme Court Rules for Professional Conduct, Rule 5.6):

> A lawyer shall not participate in offering or making:
>
> a. a partnership or employment agreement that restricts the rights of a lawyer to practice after termination of the relationship, except an agreement concerning benefits upon retirement; or
>
> b. an agreement in which a restriction on the lawyer's right to practice is part of the settlement of a controversy between private parties.
>
> [Official] Comment
>
> An agreement restricting the right of partners or associates to practice after leaving a firm not only limits their professional autonomy but also limits the freedom of clients to choose a lawyer.

Most people believe that their relationship with their physician is at least as important as their relationship with their lawyer. Other states agree, and apply nearly the same rules for the enforceability of covenants to not compete to physicians and lawyers. Missouri forbids covenants not to compete for lawyers, but not for physicians.

Conclusions

The only valid reason for a covenant to not compete is to prevent a physician from making use of an employer's confidential information. This is less of a problem in medicine than in other businesses because a treating physician has little access to confidential corporate information. More importantly, the disclosure of such information is already prohibited by the Missouri laws protecting trade secrets and confidential information.

Physicians have a limited ability to negotiate when confronted with a contract that contains a covenant to not compete. In some cases the corporation will change the contract, but in most situations they will just not hire that physician. The legislature could outlaw or limit covenants to not compete, as has been done in some states. This is unlikely as long as some physicians and most hospitals and managed care plans want to preserve them. While patient advocacy groups should lobby for the elimination of covenants to not compete, most do not realize the problems these agreements cause.

The Board of Healing Arts can promulgate a rule that prohibits covenants to not compete for physicians in the same way the Missouri Supreme Court banned them for lawyers. This would be a rule of professional practice which recognized that covenants to not compete interfere with a physician's ability to exercise independent medical judgment and thus compromise the physician-patient relationship. If the Board of Healing Arts is unwilling to ban covenants to not compete, the Legislature could direct the Board to ban them, just as it directed it to promulgate rules on collaborative practice agreements. This would minimize the intrusion on physician practices by leaving enforcement to the Board of Healing Arts.

A ban on covenants to not compete for physicians would probably be self-enforcing. If the Board of Healing Arts banned covenants to not compete, it is expected the courts would then refuse to enforce them.[4] Most contracts include a stipulation that any illegal provisions are automatically void. This means that prohibiting covenants to not compete will just affect that part of the contract with the physician. The rest of the contract will still be valid. A physician who was sued by a medical corporation for violating a prohibited covenant to not compete could quickly and easily have the lawsuit dismissed by the courts. (The courts would also be much more willing to award attorney's fees to the prevailing physician because the provisions would be clearly illegal.) This would make enforcement by the Board unnecessary and would not require any state resources.

Covenants to not compete have outlived their usefulness in physician employment contracts. It is time that Missouri abolished them for the best interest of patients and physicians. MoMed

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Edward P. Richards, III, JD, MPH, is Professor of Law, UMKC School of Law.

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Putting Quality Improvement into (Your) Practice

Part Three

Gregg R. Laiben, MD

This series of articles (Part One appeared in the February 1997 issue and Part Two in April 1997) is designed to equip the practicing physician with a knowledge base of the techniques of *quality improvement* (QI) and to provide him/her with examples of QI that can be integrated within the framework of the office practice setting. This segment will develop this concept further with a slightly more complex example of an office-based QI project.

Efforts at implementing QI techniques in the office setting are very rewarding to the physician, especially when they result in practical, useful information that directly impacts patient care. Additionally, efforts should be designed to influence as many patients as possible, in order to increase the benefit to cost ratio, thereby lessening the overall costs per patient of improving the quality of health care.

One diagnostic category that can be targeted to fulfill the above parameters is cardiovascular diseases. This is an ideal area of focus, as most practitioners see a wide variety of patients with cardiac diseases and clinical practice guidelines are readily available for use by the practice. This latter issue is not to be taken lightly: the development of a clinical guideline from scratch is a very involved, time consuming, and costly endeavor, not to be undertaken casually. It is far easier to adapt and adopt a ready-made guideline based upon the scientific literature that has been reviewed by nationally recognized experts in the field.

The development of a clinical guideline from scratch is a very involved, time consuming, and costly endeavor, not be be undertaken casually.

Nonvalvular atrial fibrillation (NVAF) is a relatively common disorder effecting about two million patients in the U.S. The primary treatment for this common rhythm disturbance is to treat the underlying etiology, which is frequently coronary artery disease. The goal is to convert and maintain the patient's rhythm to a normal sinus mechanism. However, NVAF is oftentimes difficult or impossible to convert. As a result, patients are at a great risk of embolic phenomena with stroke being a major and sometimes catastrophic end result. To help reduce the patient's five times normal risk of stroke, anticoagulation with warfarin has been shown to be very effective.

The foregoing background information on NVAF and the increased incidence of stroke, led to much scientific study with resulting recommendations for treatment with anticoagulants such as warfarin. Leading organizations, such as the American College of Cardiology, the American Heart Association, the American College of Physicians, and the National Stroke Association endorse the practice of anticoagulation in patients with NVAF to lessen the risk of stroke.

In addition to cardiologists, many primary care physicians, including internists, family practitioners, and general practitioners, care for and treat this patient population. Because of the large number of patients with NVAF, the ease of antithrombotic treatment, and the availability of scientifically valid studies supporting the need for treatment, the disorder is ideal for in-office QI efforts.

Third parties, including Missouri's Peer Review and Quality Improvement Organization (PRO/QIO), are developing programs for physicians that allow them to easily develop and incorporate an NVAF/Stroke Prevention program into their practice. The practice's doctors must first accept and buy-in to the concept that aggressive prophylaxis with antithrombotic drugs is necessary to reduce the incidence of stroke in patients with NVAF. Careful review of the current literature will help all but the most reluctant physicians overcome any initial reluctance to treatment. Treatment with anticoagulant medications is certainly not an innocuous undertaking, but the positive benefits in this patient population far outweigh the potentially negative consequences.

A frequent comment by physicians is that the chronic use of anticoagulants is difficult to monitor. This complaint is valid: careful monitoring of the patient's International Normalized Ratio (INR) is mandatory in patients receiving warfarin. However, several programs are available to help the physician ease the burden of his staff in monitoring INRs. The manufacturer of a commonly prescribed anticoagulant has recently developed two packages available free of charge to assist physicians in ongoing INR monitoring. One package is paper based and is designed for the office treating a relatively small number of patients with NVAF, the other program is a DOS-based computer software for the larger practice.

To successfully implement any type of NVAF/Stroke Prevention program, the practitioner must be able to identify which patients should be included for treatment. Clearly, only those patients holding a diagnosis of NVAF are eligible. How can the busy physician locate his/her patients with NVAF who would benefit from treatment? One could simply flip through every patient record in the office hoping to find the ideal candidates, but none of us have the time nor resources to commit such an inefficient act.

The best solution lies at the clinician's fingertips: the computerized billing system. While there are still some offices using manual billing systems, most have switched to a more efficient method. Whether using an in-house billing system or an external vendor, most software programs should be capable of identifying selected categories of patients. Since most computerized billing programs allow for the input of various diagnosis codes at the time of entry, a query of the database to identify all patients who have been seen within the last several years with a diagnosis of atrial fibrillation can be performed.

Fortunately, the diagnosis to search for (atrial fibrillation) is a single ICD-9-CM code (427.31). Once a patient list has been generated matching the diagnosis code, retrieve the patient charts and review the clinical histories for any conditions that may exclude them from participation. Obvious exclusions would be patients who are allergic to antithrombotics. Less obvious ones would include a recent surgical procedure or patients whose diagnosis of atrial fibrillation is based upon a single prior episode and who are now maintained in a normal sinus rhythm.

This step of the QI process is necessary to determine whether a patient is eligible for treatment or not. As a working clinical knowledge is necessary, it should be performed by the physician or by a trained nurse or other office assistant. Foremost in streamlining this process is designing a detailed list of inclusion and exclusion criteria before undertaking review of the patient record. Much time can be saved by doing your homework here. Most ready-made NVAF/Stroke Prevention QI programs for the practitioner have developed these criteria for you.

Once the patient population has been identified, determine a baseline rate of antithrombotic usage: how many of the patients meeting the case definition are receiving an antithrombotic drug? Are they being followed with the appropriate laboratory tests? Are the tests being performed at the proper intervals? Are some patients with NVAF not receiving any antithrombotic treatment at all?

Once the data is collected, analyze the results to determine where improvements in care can be made.

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Frequently, more than one area can benefit from improvement. Perhaps some eligible patients can be started on treatment and those already receiving treatment could be monitored more closely. The remedies to improving these two different issues should be tailored to both the specific issue and your practice. Some helpful interventions could include simple items such as a follow-up phone call or reminder stickers on charts of those patients needing an INR at the next visit. Perhaps your practice would benefit from the previously mentioned software tracking system.

Regardless of the types of interventions you choose, your practice will be well on its way to improving the care of your patients. **MoMed**

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Director, Pulmonary Outreach Program
University of Missouri-Columbia and Ellis Fischel Cancer Center

Asthma is one of the most exciting diseases that you and I have the privilege to treat. It is potentially reversible air flow obstruction, airway inflammation that can be eliminated, and hyperresponsive airways that can be quieted. I thought it would be interesting to review some of the major therapeutic advances in asthma therapy that took place in 1996. I hope you will agree that this review is time well spent. For some as yet unknown reason, more people have been developing asthma each year. The number of asthma sufferers in the United States has jumped from about eight million in 1982 to an estimated 12.4 million by the mid-1990s, an increase of more than 50%. Asthma exacts a heavy toll, causing about 5,000 deaths yearly. It results in missed school days, missed work days, and hospitalizations.

In reviewing recent therapeutic advances, I will propose 10 questions that hopefully fit into the context of your practice. It is my goal that by answering these questions, you will feel more confident that your therapeutic approach is sound and updated for the new year.

Question 1 - Are the majority of your asthma patients receiving inhaled corticosteroids?

The National Disease and Therapeutic Index (NDTI) studies trends in drug therapy for the management of asthma. The NDTI continuously samples physicians' prescribing habits, focusing on office-based care and sampling all patients encountered by conducting a survey of approximately 1% of practicing generalists and specialists. Only recently has there been a recognized acceleration in the prescription of inhaled corticosteroids. Through the 1980s fewer than 10% of office visits by asthma patients ended with the prescription of inhaled corticosteroids, and it was not until 1990 that these drugs were being prescribed to nearly 30% of asthma patients.[1] By 1992, 60% of office visits by asthma patients ended with the prescription of an inhaled beta-agonist. Probably more of these 60% would benefit from inhaled steroids.

Airway inflammation is the central pathophysiologic event in asthma. The global initiative for asthma management guidelines suggests mild persistent asthmatics should be routinely treated with inhaled corticosteroid therapy. If your asthma patients are using more than two or three doses of bronchodilator therapy weekly, they probably should also be on inhaled steroids.

Anti-inflammatory medications, particularly inhaled corticosteroids, are considered drugs of choice for the management of asthma. Biopsy studies of asthmatic airways show inflammatory cell infiltration of the bronchial mucosa. The bronchodilators we use do not correct this pathology. After treatment with inhaled steroids, repeat mucosal biopsies show significant decreases in the number of eosinophils, mast cells, and certain types of lymphocytes. Studies of bronchoalveolar lavage cells and measurements of inflammatory mediators also show significant improvement after inhaled steroids. These pathologic and pathophysiologic changes translate clinically to a decrease in asthma symptoms, improvement in pulmonary function, and a decrease in bronchial reactivity.

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Question 2 - Do you have a simple reference source for the step-care approach to asthma management?

In the early 1990s, the National Institutes of Health (NIH) began to focus on improved asthma management because of the increasing prevalence and the rising death rate from a disease that should be appropriately treated, particularly with the new therapeutic agents that are systematically being developed.

The most recent program from NIH and the World Health Organization is entitled "Global Initiative for Asthma." They have developed a Pocket Guide for Asthma Management and Prevention,[2] which I keep readily available, and which we provide to our medical residents and students. This guide clearly outlines treatments in the step-wise approach to the long term management of asthma (See Figure 1). I use this reference to be sure that each of my patients is being appropriately treated. I only need to refer to one or two clear tables.

Your pharmaceutical representative may provide you with a copy of this pocket guide, or you may write directly to the following address: National Institutes of Health, National Heart, Lung, and Blood Institute, Bethesda, Maryland, 20892, USA. (Refer to NIH publication No. 96-3659B.) You can also reach them through the Internet (http://www.ginasthma.com).

Question 3 - What should you do if the standard dosage of inhaled steroids and short-acting bronchodilators are not controlling your patient's asthma symptoms?

Many physicians now instruct their patients to double their inhaled corticosteroid dose for two weeks if the patients' peak expiratory flow repeatedly falls below some predetermined value, for example, 80% of the patients' best established morning values. This guided self-management of asthma can be helpful in many patients. However, inhaled steroids are not the only answer. (See Step 3, Figure 1)

Asthma patients still benefit from traditional bronchodilator agents such as the B_2-agonists. Salmeterol is a new effective, long-acting, B_2-agonist that provides persistent 12-hour bronchodilatation in patients with allergic and nonallergic asthma. It was introduced in this country in 1995 (Serevent®). The general consensus is that it is very useful in some asthma patients. A landmark study published by Woolcock and others in 1996 involved 738 patients.[3] The authors demonstrated that adding salmeterol to the treatment regimen was superior to increasing the dose of inhaled corticosteroids in patients who were receiving lower-dose inhaled corticosteroids and whose symptom control was poor. Patients who continue to demonstrate symptoms on conventional doses of corticosteroids can obtain better control by adding a long-acting beta-agonist to their current therapy than by increasing their corticosteroid dosage to a level at which systemic toxicity may occur.

Salmeterol is a drug that should be kept at the bedside. The patient uses it twice in the morning and twice 12 hours later. If "rescue doses" of B_2-agonist are needed during the day, it is advisable to use the shorter acting agents such as albuterol, but not more salmeterol. Studies have shown that when patients are given both compounds, they tend to use fewer total doses of B_2-agonist than when they only use albuterol regularly and prn.

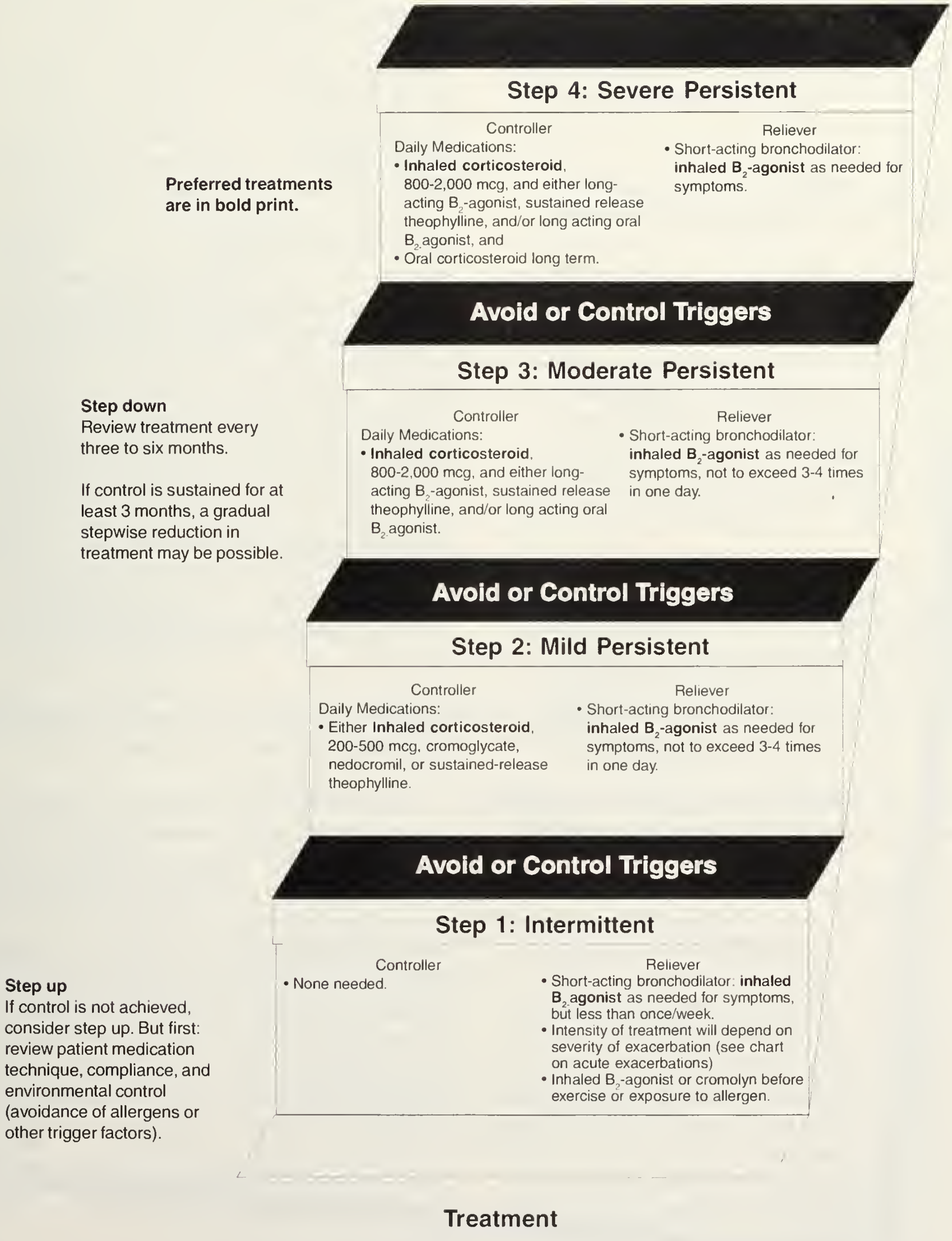
Question 4 - What antibiotic should you use for an exacerbation of asthma?

This is meant to be a trick question. Most of us use far too many antibiotics when our patients' asthma symptoms worsen. Certainly, asthma by itself can cause increasing cough, increasing sputum production, and a low-grade fever. An excellent 1996 study by Boushey and Fleming[4] reviews again the infectious precipitators of asthma exacerbations. In addition to cultures, the authors used polymerase chain reaction techniques for identifying viruses. They were able to show that viruses precipitated acute asthma exacerbations in 44% of the adults studied and in 77% of the episodes in children. Rhinovirus was the most common etiologic agent in this study.

This is a difficult clinical situation for the practicing clinician. The patient often expects an antibiotic when his/her symptoms increase. I try to

Continued on page 234

Figure 1: Step-care Approach to Asthma Therapy*



Step 4: Severe Persistent

Controller
Daily Medications:
- **Inhaled corticosteroid**, 800-2,000 mcg, and either long-acting B_2-agonist, sustained release theophylline, and/or long acting oral B_2 agonist, and
- Oral corticosteroid long term.

Reliever
- Short-acting bronchodilator: **inhaled B_2-agonist** as needed for symptoms.

Preferred treatments are in bold print.

Avoid or Control Triggers

Step 3: Moderate Persistent

Controller
Daily Medications:
- **Inhaled corticosteroid**, 800-2,000 mcg, and either long-acting B_2-agonist, sustained release theophylline, and/or long acting oral B_2 agonist.

Reliever
- Short-acting bronchodilator: **inhaled B_2-agonist** as needed for symptoms, not to exceed 3-4 times in one day.

Step down
Review treatment every three to six months.

If control is sustained for at least 3 months, a gradual stepwise reduction in treatment may be possible.

Avoid or Control Triggers

Step 2: Mild Persistent

Controller
Daily Medications:
- Either **Inhaled corticosteroid**, 200-500 mcg, cromoglycate, nedocromil, or sustained-release theophylline.

Reliever
- Short-acting bronchodilator: **inhaled B_2-agonist** as needed for symptoms, not to exceed 3-4 times in one day.

Avoid or Control Triggers

Step 1: Intermittent

Controller
- None needed.

Reliever
- Short-acting bronchodilator: **inhaled B_2 agonist** as needed for symptoms, but less than once/week.
- Intensity of treatment will depend on severity of exacerbation (see chart on acute exacerbations)
- Inhaled B_2-agonist or cromolyn before exercise or exposure to allergen.

Step up
If control is not achieved, consider step up. But first: review patient medication technique, compliance, and environmental control (avoidance of allergens or other trigger factors).

Treatment

*From Reference 2, Pocket Guide for Asthma Management and Prevention.

Continued from page 232

auscultate thoroughly to find a localized area of crackles on physical examination. That finding, along with a fever that exceeds 100°F (37.76°C), may lead me to obtain a chest x-ray in selected cases. Certainly, with localized new infiltrates, I do use antibiotics.

Question 5 - Should I be sending more of my asthma patients for allergen immunotherapy?

This question has been well studied recently, and the answer is "no." Allergy shots do not help most asthma patients.[5] Certainly, measures to avoid allergens should be stressed, and environmental controls for the allergy patient are important. No matter how good our therapies, when possible, avoidance of allergen exposure is still the best treatment. Maybe the number one challenge should be that no one in your asthma practice is also a smoker.

Specific immunotherapy, directed at treating an underlying allergy to grass and other pollen, domestic mites, animal dander, or Alternaria, may be considered when avoiding allergens is not possible or appropriate medications fail to control asthma symptoms. Specific immunotherapy should be performed only by trained health professionals.

Question 6 - Should all of your asthma patients be measuring peak expiratory flow (PEF) at home?

Compliance with routine home PEF monitoring in adults has been found to be low (54% in one study, with 22% of the entries invented!) and that is the experience in my practice as well. But, for the moderate and severe patients you see, they should at least have a peak flow meter at home, know what their personal best peak flow is, and begin to record peak flows if they have any concern that their asthma is worsening, as well as to provide you with objective data should they call you.

Your asthma patients should have a written plan for asthma emergencies. I stress the word "written" because patients who are ill and are becoming increasingly short of breath often begin to panic, and help should be very tangible and easily accessible. If an independent surveyor called a sample of your patients (and mine), hopefully these patients could answer "yes" they have such a plan (Figure 2). If the patient measures peak flow, there should be a level at which they adjust their therapy or call you if they are consistently falling below those peak flow values. They should have certain symptoms and warning signs where they should promptly arrange an office visit. They should know when to come to the emergency room in more urgent attacks. And whether they come to your office or the emergency room, these locations should quickly have objective measurements of lung function to assess the severity of episodes and evaluate the response to therapy. Peak flow meters provide tangible evidence of the degree of obstruction. These measurements compliment your physical exam or the evaluation by a health care provider (e.g. in the E.R.) who has never seen this patient before. It has been well documented that physicians perform poorly in their ability to estimate the severity of air flow obstruction in patients with asthma. If you want to pursue reading on this subject, I would suggest a recent article by Emerman, et al.[6]

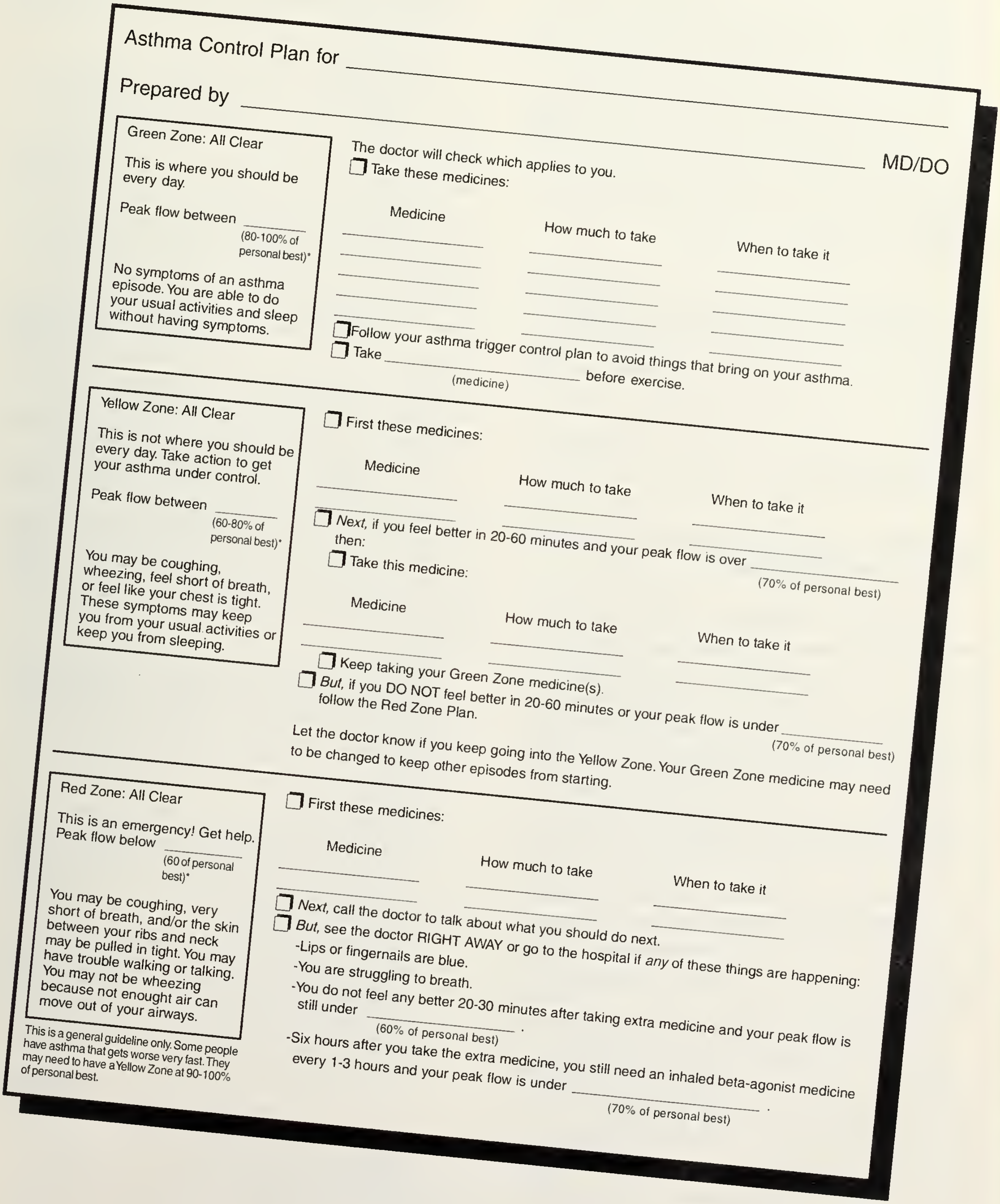
Question 7 - Does it matter what inhaled steroid my patient uses and how the patient uses it?

Since inhaled corticosteroids are the basic foundation for modern asthma therapy, the answer is a resounding "yes." You should be familiar with the drug used, and you should feel the patient is taking the medicine in the way you have prescribed it. Many asthma patients do not notice any immediate relief from inhaled steroids and tend to skip doses of the drug or eliminate them completely. You should point out to your patients that the effects are long-term, and they are not to limit or taper the doses of this drug without your precise recommendations.

Prior to 1966, inhaled corticosteroid therapies administered by MDI were limited to beclomethasone, triamcinolone, and flunisolide. Which one we prescribed was based on a number of factors: our familiarity with the drug and our success using it; cost; type of delivery system; "built-in"

Continued on page 236

Figure 2: Elements of a Simple Action Plan*



Asthma Control Plan for ____________________

Prepared by ____________________ MD/DO

Green Zone: All Clear

This is where you should be every day.

Peak flow between ______
(80-100% of personal best)*

No symptoms of an asthma episode. You are able to do your usual activities and sleep without having symptoms.

The doctor will check which applies to you.

☐ Take these medicines:

Medicine	How much to take	When to take it

☐ Follow your asthma trigger control plan to avoid things that bring on your asthma.

☐ Take ______ (medicine) before exercise.

Yellow Zone: All Clear

This is not where you should be every day. Take action to get your asthma under control.

Peak flow between ______
(60-80% of personal best)*

You may be coughing, wheezing, feel short of breath, or feel like your chest is tight. These symptoms may keep you from your usual activities or keep you from sleeping.

☐ First these medicines:

Medicine	How much to take	When to take it

☐ *Next,* if you feel better in 20-60 minutes and your peak flow is over ______ (70% of personal best) then:

☐ Take this medicine:

Medicine	How much to take	When to take it

☐ Keep taking your Green Zone medicine(s).

☐ *But,* if you DO NOT feel better in 20-60 minutes or your peak flow is under ______ (70% of personal best) follow the Red Zone Plan.

Let the doctor know if you keep going into the Yellow Zone. Your Green Zone medicine may need to be changed to keep other episodes from starting.

Red Zone: All Clear

This is an emergency! Get help.
Peak flow below ______
(60 of personal best)*

You may be coughing, very short of breath, and/or the skin between your ribs and neck may be pulled in tight. You may have trouble walking or talking. You may not be wheezing because not enought air can move out of your airways.

☐ First these medicines:

Medicine	How much to take	When to take it

☐ *Next,* call the doctor to talk about what you should do next.

☐ *But,* see the doctor RIGHT AWAY or go to the hospital if *any* of these things are happening:

-Lips or fingernails are blue.

-You are struggling to breath.

-You do not feel any better 20-30 minutes after taking extra medicine and your peak flow is still under ______ (60% of personal best).

-Six hours after you take the extra medicine, you still need an inhaled beta-agonist medicine every 1-3 hours and your peak flow is under ______ (70% of personal best).

This is a general guideline only. Some people have asthma that gets worse very fast. They may need to have a Yellow Zone at 90-100% of personal best.

*From Reference 2, Pocket Guide for Asthma Management and Prevention.

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spacer; taste; etc. Now, we have fluticasone for the management of chronic asthma, and in the near future, we will have budesonide. Both agents exhibit a greater degree of relative topical and systemic potency than do the aforementioned corticosteroids.

The introduction of the first new inhaled steroid in 11 years, fluticasone propionate (Flovent™), came in 1996. This long-acting steroid may be a significant addition to our armamentarium. One article I recommend is by Johnson.[7]

A word of caution if you choose to use fluticasone. There are three strengths. Most cases of chronic asthma can be managed with 176 µg/day, some with 440 µg/day. More severe asthma (Step 4, Figure 1) can be managed with fluticasone > 440 µg/day, at which point the potential for a higher relative systemic potency becomes more likely, but also more acceptable if the alternative is oral prednisone therapy.[8]

Question 8 - How much theophylline should I be using in my asthma patients?

Weinberger and Hendeles reviewed theophylline in asthma in a comprehensive review in the *New England Journal of Medicine*.[9] They found that theophylline was certainly no longer a first-line drug. Many asthma patients are well controlled without it. It is recommended that theophylline also not be used in the emergency department for the treatment of asthma. However, they went on to state that the addition of theophylline to standard drug therapy may be appropriate for patients with respiratory insufficiency not rapidly responsive to standard treatment. They also suggest that theophylline has value as a maintenance therapy in patients with chronic asthma, particularly patients with nocturnal asthma. (Step 3, See Figure 1)

The challenge with theophylline is that proper dosing of this agent requires careful dose titration and the ability to recognize certain risk factors indicating toxicity, including patient age and the presence of concomitant diseases that can affect liver metabolism. Theophylline elimination is increased with exposure to smoke. The narrow therapeutic index of theophylline limits its usefulness in the management of asthma.

Question 9 - Is there help for me in educating the asthma patient?

We all know how busy our present office practices can be. There are excellent publications to assist with the education of your asthma patients. To begin with, I would suggest the patient information booklet entitled "What You and Your Family Can Do About Asthma."[10] There are other materials available, and it is important to involve your patients in managing their asthma to prevent problems and to enable them to live physically active and productive lives. With your help, asthma patients can learn to: take medication correctly; understand the difference between "quick-relief" and "long-term preventive" medications; avoid triggers; monitor their status using symptoms and, if possible, peak expiratory flow indicators; recognize signs that asthma is worsening and how to take action; and seek medical help as appropriate. As stated before (Question 6 and Figure 2), you and your asthma patient should work together to prepare a written asthma management plan that is not only medically appropriate, but is practical as well.

In addition to using an asthma education booklet, I suggest a few education guidelines to be mentioned to each patient. I am sure you have your own, and I will state some of mine here only for the sake of comparison:

1. Don't smoke.
2. Allergen avoidance is the best therapy. Don't depend on asthma medicine, especially extra doses, to suppress symptoms if you can avoid or eliminate the allergen.
3. A drug such as albuterol is "quick relief" or rescue medicine. If you use salmeterol, keep it at the bedside and use only two doses daily because it is long-acting.
4. If we have agreed you need inhaled steroids, take the dose exactly as prescribed. You do not feel any immediate effect, but the drug is working to decrease inflammation. On the other hand, you can skip any or all doses of albuterol if you feel no symptoms. The drug works quickly when needed.

5. If you are using more than the prescribed (allowed) dosage of albuterol, or if you are tempted to take extra doses of theophylline because you are not feeling well - DON'T. Seek medical advice or medical attention promptly.
6. Asthma need not be a progressive disease or even a bothersome one. Follow our plan and your life-style and health can become and remain normal and uninhibited by symptoms!

Question 10 - Should I be using the new leukotriene modulators?

In late 1996, the first of the leukotriene modulators was introduced for clinical use in this country.[11] The leukotriene receptor antagonist and synthesis inhibitors act on products of the arachidonic acid cascade. This cascade leads to the generation of compounds that have relevance in the mechanisms of asthma. The leukotrienes can contract airway smooth muscle, increase vascular permeability, stimulate mucous secretion, and decrease mucociliary transport and clearance. Leukotrienes may also play a role in perpetuating the inflammatory response.

My father, who was a family physician, said "don't be the first to use a new drug, but don't be the last." I think that remains sound advice. The use of leukotriene modulators or inhibitors was discussed at the latest national meeting of the American Thoracic Society and common consensus was that where these agents fit in the step care approach for the treatment of asthma is yet to be determined. For now, I recommend that you allow the consultants that you use for your more difficult asthma management cases to be the ones to advise you where this new category of therapy best fits. I predict it will take a couple of years before we know the answer more clearly.

Summary

I hope this brief update helps you feel more confident that you are current in your asthma management practices. I feel that you definitely will be if you follow the Pocket Guide for Asthma Management, if you are using inhaled steroids in the majority of your patients, and if you are considering the use of long-lasting B_2-agonists and more potent inhaled steroids in at least some of your asthma patients who reach steps three and four of therapy. Continue to be vigilant for further progress in asthma management. Best wishes for 1997 in your professional lives and specifically in managing your asthma patients! MoMed

The Author

Dr. Bode is a pulmonary specialist at the University of Missouri-Columbia in the Department of Internal Medicine and Ellis Fischel Cancer Center.

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11. Zafirlukast (Accolate•) Zeneca.

Membership Notes

Charlie White, MD, a 91 year old retired anesthesiologist from Shawnee Mission, KS, recently joined three other doctors, two nurses, and six volunteers on a 10-day mission to Haiti. The Haiti Episcopal Learning Partnership (HELP) is working to develop primary education and health care programs in Haiti. It employs more than 50 teachers, health care workers and others in Haiti.

The medical team treated patients for malaria, upper respiratory infections and high blood pressure. They also dispensed drugs and vitamins.

Ralph G. Dacey, Jr., MD, professor and chairman of neurological surgery at Washington Univerity-St. Louis, received a $1,425,357 five-year grant from the National Institute of Neurological Disorders and Stroke for a research project titled, "Hypoxia-Reoxygenation and Regulatory Mechanisms."

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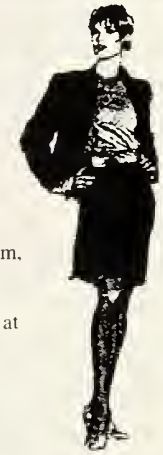

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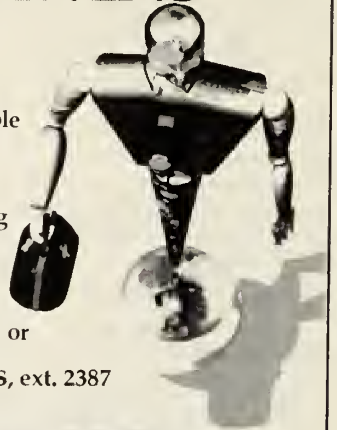

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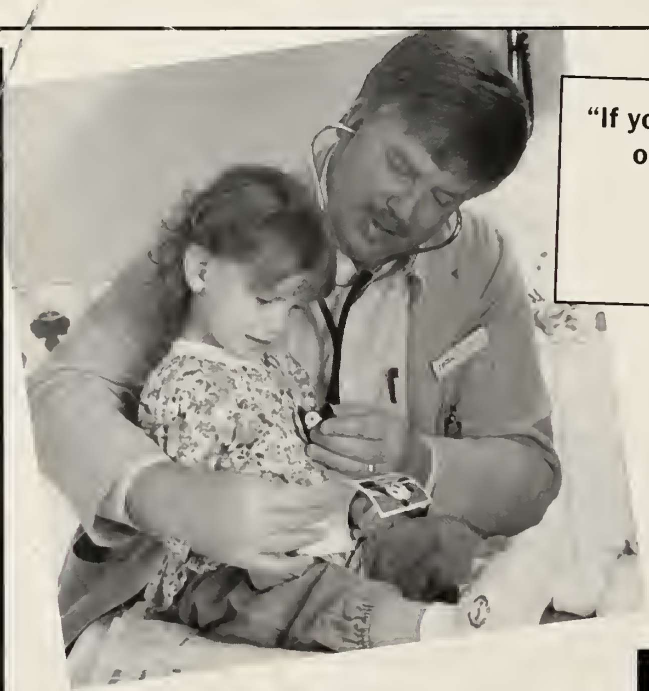

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Presidential Address by Daniel F. O'Sullivan, MD

Presidential Address given by Dr. Daniel O'Sullivan, April 10, 1997, during the First Session of the House of Delegates at the Westin Crown Center in Kansas City, Missouri.

These are the good old days. A senior physician from the Illinois State Medical Society told me he uses these words when he discusses the future of medicine with potential recruits.

On first hearing such comments, we might be concerned that he is a little too senior. But perhaps he recalls the good old days as the time when the horse and buggy doctor made home calls and did home deliveries.

Perhaps the good old days were the late twenties when no American had any money and when physicians used to race to make house calls because the first man on the scene was the one who got paid.

My father graduated from medical school in 1927, and went into practice in St. Louis in 1930. He and my mother would sit in the office waiting and praying for a patient to come and they would play gin rummy until they both became extremely skilled at that game.

Were the good old days post World War II with the arrival of penicillin and the return of doctors from the war, highly educated in quick judgment and firm action?

Or how about the mid-fifties when cardiac surgery became a reality and we spent years harvesting the atrial septal defects and ventricular septal defects that had waited for the moment when these things could be repaired.

President Daniel O'Sullivan, MD, addresses the First Session of the House of Delegates.

No, the good old days are now. Now we have CT scans and MRI scans and PET scans. We have ultrasound. Fiberoptic instruments that are flexible and can be put in every orifice in the body, including the abdomen and the chest to just look around.

We operate on TV. We operate through microscopes. We remove cataracts as if we were flicking off the leaves of a four-leaf clover.

A patient arrives in the emergency room with evidence strongly suggestive of acute myocardial infarction and within 30 minutes has a balloon in the artery at the site of occlusion and many times the vessels can be opened and damage to heart muscles prevented.

Hospitals, which years ago could not safely perform surgery for appendicitis, are today successfully and safely doing coronary artery bypass surgery.

Invitro fertilization has advanced to the frightening point of cloning, not as a science fiction possibility, but as reality.

Advances in medication and technology have removed from the menu of the surgeon all those delicious items which used to be the daily fare. The patients are better, the physicians are better, and the hospital facilities are incredibly better.

These are the good old days. Quality of care delivered in this country exceeds that anywhere in the world, including Europe and Russia and England and Japan. Physicians, that means doctors of medicine and doctors of osteopathy, are delivering that care. No one else delivers health care. Hospitals do not. Universities do not. HMO's, PPO's, and CEO's do not deliver health care.

If these are the good old days, then why are we all so damned mad?

Medical school applications are at an all-time high. Both St. Louis University and the University of Missouri School of Medicine at Columbia had approximately 7,000 applicants for about 100 places last year.

Of those 7,000, one hundred could get in any medical school they

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wanted. A hundred probably can't read or write and couldn't get in anywhere. But the lion's share of these applicants have a grade point average of 3.6 to 3.8, M-CAT scores of 28 to 30, and a relative or a friend who is a doctor and willing to harass the admissions committee to see to it that their particular candidate is accepted.

These young people believe in the future of medicine. The majority of the public still reveres their own doctors, but we continue to be criticized and deprecated by those who stand to gain the most from the subjugation of physicians.

Divide and conquer has become the battle cry of big business and they try to control all aspects of medical care. At first it was the attempt to separate the radiologists, anesthesiologists, and pathologists or hospital-based physicians from those of us who used hospitals from the outside. For the most part, medicine has successfully resisted this division and those of us in the clinical specialties have stood by our hospital-based peers.

More recently the attempt has been made to separate primary care physicians from specialists. This is accomplished in several different ways including a strong and rigidly enforced gatekeeper concept, capitation of both primaries and specialties, and extending all the way to global fees internally distributed by a financial committee.

Fragmentation in our ranks involves other aspects of the interpersonal relationship. Recently the Missouri Academy of Family Practice has taken exception to the Missouri State Medical Association suggesting that our Council represents specialists and not primary care physicians. This is blatantly untrue as even a casual glance at our numbers would show very strong representation of internists and family practitioners on our Council and many of our committees.

Our President-Elect is a primary care physician. Your Council and your President are working toward the goal of resolving this issue and we trust that the primary care physicians will continue to provide great input into our legislative and professional positions.

The second area of fragmentation of medicine is the perception that international medical graduates are suppressed. The St. Louis area alone has three international medical graduates on the Council at the present time. Many of our most outstanding St. Louis members and a recent president of the St. Louis Metropolitan Medical Society have been international medical graduates.

It worries me that we need to form sections in the AMA and the State Medical Association to represent the desires and rights and privileges of international medical graduates. It seems to me that the ideal solution for this perceived inequity would be to address it in open forum. I fear the separate representation will be a source of greater fragmentation.

The third area of division in medical care continues to be discontinuity in the direction and purpose of the Missouri State Medical Association and the Missouri Association of Osteopathic Physicians and Surgeons.

We, your Council and staff, meet quarterly or more often with MAOPS and the State Board of Healing Arts. The purpose of these meetings is to present a united front of medicine to the Board and to create a more friendly environment between our licensing and disciplinary body and the two major organizations of public providers of health care.

Because we differ on the direction and shape certain pieces of legislation should take, your Association has been accused of being obstructive to the goals of the Missouri Association of Osteopathic Physicians and Surgeons.

The Executive Committee of your Council has very patiently and politely made every effort to maintain a friendly and cooperative attitude at these meetings. We are well advised and well guided by our outstanding leadership on our staff.

We will not capitulate from our position of strength and will support only those legislative and professional positions which we feel are most advantageous to our own membership and most loyal to our Executive Vice President, Cork Swarens, and his fine staff.

For years our legislative and lobbying efforts have been directed in a reactive fashion supporting that legislation which seemed favorable to us and opposing that which we saw harmful to our patients and to medicine generally.

About three years ago the legislative committee voted to adopt a new approach. We became pro-active and sponsored legislation promoting certain insurance changes and patients' right. Suddenly our adversaries were spending their energy resisting our efforts.

Of course, we had difficulty getting these issues approached, but many of the things we sought will be accomplished by the Kennedy-Kassebaum bill. Our patient rights bill was considered by many to be an any-willing provider act.

Finally, as a result of a deluge of proposed legislation from many quarters, Governor Carnahan last year appointed a commission to study managed care. The legislators represent both parties and both houses. Hundreds of individuals traveled to Jefferson City to testify before the commission. These elected representatives were clearly shocked by the testimony they heard.

Out of this committee came House Bill 335 containing some 30 points almost universally favorable to the patients and accomplishing many things your medical society has worked for.

This bill is now out of the house nearly unchanged and awaits senate approval. Countless hours of lobbying, negotiating, cajoling, and begging by Cork Swarens and Tom Holloway have been the main ingredients in the apparently favorable handling of this bill.

Mr. Swarens has been a respected representative of medicine in the Capitol for years. He and your Council are extremely proud of the emergence of Tom Holloway as an effective, intelligent, and clever representative of MSMA. We are definitely having a major effect on legislation in Missouri.

Four years ago this summer it became clear to the Council of MSMA that we needed to prepare our members for a response to the onslaught of managed care. The Clinton bill was upon us nationally and the Carnahan bill in Missouri looked even worse for medicine.

A committee was formed to study the appropriate response of MSMA to help our members. We formed a corporation called Missouri State Medical Services, Incorporated, for the purpose of advising and assisting our members in such matters as managed care contracting, mergers, professional organizations, management information systems, and so on. We molded our model after a similar organization in Kansas.

After interviewing applicants, we hired Mr. Tom Bennett, an experienced and educated health care executive. In the past three years he has traveled Missouri as an evangelist for physician organizations. He has consulted, advised, and assisted many groups in the formation of IPA's, PHO's, and other groups. Many of our members have complimented the MSMA for providing his services.

MSMS with the approval of the Council of MSMA has just contracted with St. Louis Management Group to form Physician Resource Network, PRN, a joint venture between these two organizations. This will be an MSO, a management services organization, which will provide a statewide support network to the independent IPA's and other organizations of commonality uniting them under the endorsement in and reassurance of the Missouri State Medical Association.

It will also be a means to provide even further benefits to our members. Brochures have been developed in the last week, and are present in the scientific area for distribution, describing the services group to be provided by PRN. Phone numbers are available for immediate use for those interested in inquiring about the services provided and the MSO will be fully operational by July of this year.

Over the past years as your president I have traveled to all corners of the state at the invitation of county medical societies. Your staff and I have met with members and potential members trying to advise them of the advantages of membership.

Jeff Howell, Director of Field Services, has accompanied me on most of these occasions. His imaginative approach to recruiting has been of great benefit. Membership, however, remains our greatest challenge. The work we do benefits not only the members of our Association, but also that other half of the licensed physicians in the state.

It is time they came aboard the ship. It is time they paid their share of the passage. For our perspective to be more effective, we need them to say they know we represent them.

A phone bank is available in the scientific area where each delegate, each member, can make one phone call from this convention and call a fellow physician in your home area and solicit his membership. We encourage your participation in that program.

Additionally, in the last year I have met with many groups which might appear adversarial. We have tried to make friends with the medical directors of managed care organizations in Kansas City and St. Louis. We have met with the presidents of the county medical societies, with Heartland Medical Group of Kansas, and have attended meetings of both the Illinois and Kentucky state medical associations. Several meetings with AMA representatives in Florida, Atlanta, Philadelphia, and Chicago complete the travelogue.

Through these experiences I can assure you that the state of the Medical Association of the State of Missouri is equal to that of any state. Our CME program, supervised by Ron Ellison, Director of Scientific Affairs, approves most of the major teaching programs and conferences throughout the state of Missouri. Ron also is responsible for the arrangements at the annual meeting and all our Council meetings. His quiet demeanor disguises a loyal and hardworking member of our team.

Jeff Howell, whom I previously mentioned, has also been active in internet activities.

Liz Starnes, Director of Communications, has been most helpful in promoting the Internet services. She was a prime mover of an excellent series of medical infomercials shown statewide on commercial TV and produced a membership video of high quality which is available to all our county societies. She also is responsible for *Progress Notes*, which is a highly respected communication sent to all our members.

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Michelle Poire is managing editor of *Missouri Medicine* and replaces Angie Allen.

Other valuable staff members include Barbara Crader, Membership Secretary; Becky Jungermann, Executive Assistant; Brenda Kinney, Finance Manager; and Mary Wiegers, Receptionist.

Linda Bremer, our Office Manager, was suddenly thrust into her present position and has risen remarkably to the occasion and is doing an absolutely excellent job.

When I became active in the leadership of MSMA, a young man joined the staff of MSMA as Director of Health Care Finance. He and I have been educated together—that is, me by him—in the intricacies of managed care and the alphabet soup of HMO, PPO, IPA, et cetera. Patrick Mills, a graduate of K-State, with a MBA, is an extremely intelligent visionary who, I hope, will be a loyal and active member of MSMA staff for years to come.

Finally, I had the pleasure of being on the Nominating Committee to select the replacement for Royal Cooper more than two years ago. Our unanimous selection after reviewing many capable individuals was C. C. Swarens, our Executive Vice President.

I have had the pleasure of observing him more closely than most of you, and I assure you that he is a strong, fearless, and extremely responsible Executive Vice President.

The past year has been a challenging and eye-opening period. The Council of MSMA is inspiring in its loyalty, support, and participation. We rarely have an absentee at our Council meetings.

The officers, that is, the Executive Committee, consists of our Secretary, Norman Knowlton; Treasurer, Ed Cabbabe; Vice Chair, Bill Dorzab; Council Chair Stephen Vilmer, who has done a wonderful job; and Past President Fred Hahn; First Vice President, David Wilkinson, who is a personal friend, has served as a Councilor, a good supporter and, as he says, my chauffeur.

A. J. Campbell has been quietly at my side supporting everything we have tried to accomplish over the past year. He will be an outstanding and strong president.

The last part of our army is the Alliance. The word "auxiliary" means to help. The word "alliance" implies working together, standing shoulder to shoulder, and working toward the same purpose, to provide the patients of Missouri with the best, kindest, and most efficient care available. We will soon hear a report of the activities of our Alliance this year and you need only listen to be proud.

As this year comes to a close, we should all renew our enthusiasm for organized medicine. We can continue to accomplish much together. We can preserve the pride and dignity of the office of physician. After all, these are the good old days. Thank you very much. **MoMed**

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A.J. Campbell, MD, Installed at the 139th Presidential Inaugural Ceremony

The following is the Presidential Inaugural Address given by Dr. Campbell, April 12, 1997, at the Westin Crown Center in Kansas City, Missouri.

Dr. O'Sullivan congratulates Dr. Campbell.

Thank you. Thank you, Dan, for your kind words and for your strong leadership and hard work this past year.

And thank you for allowing me the opportunity to serve as the president of this wonderful organization.

To follow in the footsteps of the 138 men and women who have served before me. Although I wear a size 13 C shoe, those before me have left big shoes to fill.

Not only the presidents but many of our state's other outstanding leaders. Leaders like Hugh Stephenson.

Hugh is not only one of my mentors, but one of Missouri's finest physician leaders. He believed in me and inspired me to apply to the University of Pennsylvania Medical School, after completing the two-year program offered at Missouri at that time.

Although Hugh is a great physician, I have always thought he missed his calling and should have been a fiction writer. Or at least an advertising copy writer.

The letter of recommendation Hugh wrote for this good ol' Sedalia boy had to have been a great work of fiction. For it got me in.

Although Hugh couldn't be with us this evening in body, I'm sure he is in spirit.

I'm only one of many in this room who has great admiration for him. He's been such a great role model and mentor for so many . . . so please join me in honoring Hugh Stephenson for all he's done for Missouri medicine.

He is Mr. Missouri Medicine!

My other mentor, of course, was my father, A. J. Campbell, Senior, who was a general practitioner in Sedalia for more than 50 years. He gave me life, but even more, he gave me a living. And what a wonderful living a life in medicine can be. He never urged me to become a physician, but always said "You can do it if you really want to, and I will help you anyway I can."

Good words of support then, and a pledge of support I make to you this evening as your new president. I see three challenges facing Missouri physicians this year, to which I pledge your leadership's support.

Membership, managed care, and mending the medical family ties.

First, membership. Increasing our numbers has to be one of our top priorities. It is our lifeblood. We are beginning to rebound from the slump in membership that we felt in the mid-nineteen nineties. And to date, we are nearly six thousand strong. But, that is only half of what we could be.

Membership support of MSMA is essential. What other organization can protect physicians and their patients from those who seek profit at the expense of appropriate medical care and reimbursement? What other organization can speak with one voice? Can stand up to these outside forces and special interest groups?

None other than this, our Missouri State Medical Association.

Just look at our recent record of achievement these past few years for both patients and physicians.

First, remember that unworkable national health care plan they tried to hand us three years ago? I sure do! We joined with the American Medical Association and others in the medical federation to prevent the government take-over of our health care system.

And I know you'll remember back, when for-profit insurance companies couldn't see the profit in providing Missouri physicians with liability insurance. It was MSMA that stepped up to the plate and filled the void. Responded to our need.

We formed MOMEDICO which, as you know, for the past 19 years has provided liability insurance for Missouri physicians...and peace of mind for our patients.

And, we take responsibility for our own. In 1978, when we saw that some physicians were having life problems or substance abuse problems, and were in danger of losing their licenses, and in turn, their patients losing them.

It was MSMA that formed the Physicians Health Program. We have a 94% success rate. Returning Missouri physicians not only to their practices, but also to their patients. And, as the practice of medicine is changing, so is the state medical association, in responding to that change.

In 1989, as physicians began to look for ways to work more effectively through their hospital medical staffs, MSMA formed a section for them. Today, called OMSS, it functions to provide a voice for medical staffs, and to provide due process in hospital privileging and disciplining actions.

That's a pretty good start on a long list of achievements that Missouri physicians can be proud of. Can you see the fruits of what happens when physicians labor together for a common good. All pretty darn good reasons for joining our organization.

Our membership challenge could be readily met if each member would recruit just one new member.

My one this month is Derreck Menefee. Derreck is a fourth year medical student from Sedalia studying at UMKC. And he's come a long way from the skinny, little kid who used to mow our grass. He spent part of his preceptorship with me this spring in family medicine.

I don't know whether I have convinced Derreck to specialize in family medicine. But I do know that I've won his pledge of membership and participation in organized medicine. And he'll be in good company when he becomes active in organized medicine . . . company like Jason Burns, another Sedalian who has shown his interest in organized medicine performing this year as State Chair of the MSMA-Medical Student Section.

We need young physicians like Derreck and Jason and like those you come in contact with in your offices and in your classrooms. They are literally the future of our association.

Our second challenge is the challenge of managed care.

Whether it is in the halls of our hospitals or the aisles of our House of Delegates, like you, I hear a lot of fussin' and fightin' about managed care. But, I think we are focusing on the wrong term.

We should be focusing not on managed care, but on medical decision making. Who is making–and who should be making–the medical decisions for patients. I want to focus this year on helping us fight for our patient's right, to return the medical decision making to the patient in consultation with his or her physician.

And, if you have all done your homework, those rights may become a reality in the next 20 days. I hope all of you and your colleagues have contacted your legislators. Asking them to support the managed care reform bill currently in our Missouri legislature.

This bill is the result of three years of hard work by MSMA on behalf of Missouri patients and physicians. Of course, legislation is not the only area in which MSMA has been operating on our behalf to meet the challenge of managed care.

We are developing Missouri's own medical service organization. We have had enough of the intrusion into the medical care decision making. And, we are not going to take it any more.

Our own MSO will allow us to take control of how to treat patients. Who can be our patients. And, how much care is needed for our patients.

Our MSO will be able to refer our members to experts to get contracting advice and other consulting services. Such services as practice acquisitions and sale of practices. We need qualified advisors and consultants when dealing with the financial and management challenges in managing today's medical practices. And, our MSO will be there to help us meet those challenges.

I am excited and proud of this, our newest venture. And I hope you are, too.

Of course excitement and pride are not enough. What we physicians need to do now is sign up and speak up. Be sure each and every one of our colleagues knows about these services and is encouraged to take advantage of them. We will be hearing more about these services when they become fully operational July 1, 1997.

Our third challenge is the hardest and the saddest of all for me to talk about this evening.

It is the mending and repairing of our medical family's ties.

What do I mean by that? I mean that, when I attended the AMA's Leadership Conference last month I heard horror stories from other medical leaders that left me so dismayed at what's going on in some other parts of the country. And, left me determined not to let it happen here in Missouri.

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One state president told me of attending her son's Little League baseball game and observing two physician fathers, sitting at opposite ends of the bleachers.

Not because their sons were on opposing teams, but because they worked at opposing hospitals. And they weren't speaking. The two hospitals were fighting over who was going to win the right to the one linear accelerator approved for their town.

Collegiality among old friends has lost out to a clash over cold, hard finances. Thank goodness that's rare here in Missouri and with your help, it always will be. I pledge to work toward stopping this petty bickering, at the expense of professional respect and courtesy, that threatens our profession, that diminishes us all.

Throughout my travels around the state this coming year, I want to work to rekindle the respect and friendship among physicians and their families.

And to work toward restoring that genuine family-of-medicine attitude that I found among physicians and spouses in my early days of practice.

The Alliance members, the men and women who are our spouses . . . and work so hard on our behalf . . . are doing their part. Now, we physicians must do ours.

I opened my remarks this evening sharing with you the story of two of my mentors, my teachers who have guided me so well in my medical career. But, neither would have had a medical student to guide through medicine without the presence of a third teacher in my life.

Miss Mila Swearingen, my sophomore English teacher at Smith Cotton High School in Sedalia. I'll never forget the day Miss Swearingen assigned the class an essay about what we wanted to be when we grew up. Of course, I wrote about following in my dad's footsteps and being a doctor.

She said, "Well, if you're going to be a doctor, you'd better get serious about it. These grades may never get you into medical school."

Although she probably assigned a "satisfactory" to my theme, she let me know in no uncertain terms, that my performance was far from living up to my capabilities, by her standards.

She really got my attention, as those of you lucky enough to have your own Miss Swearingens will remember how scary those wonderful old teachers could be. I shaped up. And, I would be remiss if I didn't pay my respects to her this evening.

I would also be remiss if I didn't recognize so many family and friends who have helped me be here. As I call their names, I would like them to rise, but I would ask that you hold your applause until all have been introduced.

First, Janet, my wife. My best friend and partner. For 43 wonderful years. And, our three children. Daughter Becky Campbell and her husband Mark Lefebvre. Becky practices oncology in Raleigh, North Carolina. Our son, A.J., the third, who is a surgeon in Columbus, Ohio. With him is a long, long time girlfriend, Stayce Besst, whom we love as our own. And our youngest Bob, who is with the Boeing Company in Wichita. We regret that Bob could not be with us this evening. My sister Nancy, and her husband Burr Young from Hilton Head, South Carolina and their family. Jan's sister Betty and her husband Ed Blakeley from St. Joseph and their family. My wonderful office staff. Office manager and my right hand, Diann Brattain, and staff Ruth Ann Dove and Pam Leet. And, the physicians and spouses of the Pettis County Medical Society, and our many special friends, from Sedalia and beyond.

And then, there's our excellent state medical association staff. I know that Dan expressed his appreciation for all of the work that Cork Swarens and his folks do. But I want to be sure to add my accolades. And now, please help me express my love and appreciation to all of them.

And, now, I am going to issue my first presidential order. Please march next door and join Jan and me for an evening of celebration. Thank you. MoMed

Barry Hyatt
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Minutes of the House of Delegates

FIRST SESSION

The first session of the 139th House of Delegates began at 10 a.m., Thursday, April 10, 1997, with the official call to order by Speaker of the House, Frederick Defeo, MD. President Daniel O'Sullivan, MD, gave the welcoming remarks.

Charles Van Way, MD gave the report of the Committee on Credentials: nine officers, 30 councilors and vice councilors, and 76 delegates were in attendance. This report and the minutes of the 138th Annual Convention as published in the May 1996 *Missouri Medicine* were approved.

Speaker DeFeo announced the members of the Reference Committees as follows: *Reference Committee A:* Steve Buie, MD, Chair; Octavio Chirino, MD; William Haynie, MD; Kathy Lentz, MD; and Mina Bradford, MD. *Reference Committee B:* Richard Gimpleson, MD, Chair; Barbara Buchanan, MD; Hal Lurie, MD; Ed Masters, MD; and Ken Rall, MD.

MSMA President Daniel O'Sullivan, MD, addressed the House. His remarks begin on page 245 of this issue. President-Elect, A.J. Campbell, MD, briefly addressed the House.

MSMA Alliance President Joan H'Doubler reported the Alliance activities for the past year. Her remarks begin on page 293.

Dr. O'Sullivan introduced featured speaker Richard Corlin, MD, Speaker of the House of Delegates of the AMA. Dr. Corlin is a practicing gastroenterologist from Santa Monica, California, and was recently re-elected to the post of Speaker. He has been active in the AMA for 17 years, serving on various committees and as a spokesperson for the AMA. In 1992, Dr. Corlin was invited by the Secretary of Health and Human Services to serve as a member of the Advisory Committee to the Director of the National Institute of Health. He is a past President of the California Medical Association and served as Vice Speaker and Speaker for the CME House of Delegates and as a member of the Board of Trustees. Excerpts of Dr. Corlin's address begin on page 267.

Dr. O'Sullivan presented awards to Jack Croughan, MD, and Robert Bondurant, LCSW, RN, in recognition of their service and dedication to the Missouri Physicians Health Program.

The Citizenship and Community Service Awards were presented by Dr. O'Sullivan to James Blaine, MD, Springfield; William Gondring, MD, St. Joseph; and James Kinder, MD, Cape Girardeau.

Dr. DeFeo introduced Candace Keller, MD, a member of the Board of Directors of the AMPAC. Dr. Keller presented Mel Kasten, MD, Chair of the MSMA MMPAC Committee, with the 1996 AMPAC Membership Award.

r. O'Sulliva
Dr.
Missouri State Medical Association
Service Award
Jack L. Croughan, MD
Missouri Physicians Health Program

Robert Bondurant, RN, LCSW, and Jack Croughan, MD, were honored for their service and dedication to the Missouri Physicians Health Program.

Vice Speaker Rollo called on Turner Minnigerode, MD, to give the Missouri Patient Care Review Foundation report. Dr. Minnigerode reported that MPCRF was awarded a new three-year contract by HCFA to continue as Missouri's federally-designated peer review and quality improvement organization. Carl Bynum has recently assumed the job of Principal Clinical Coordinator. The CLAIM program which provides insurance counseling for Medicare beneficiaries was recently honored by the Governor and the Division of Aging. The MPCRF is involved in cooperative projects with Medicare Risk HMO's. The Missouri PCRF has maintained a concern regarding the impact of managed care on the quality of patient care and continues to feel the independent external oversight is needed. AMAP, which is in the process of being further defined by the AMA, presents the possibility of collaboration between MSMA and MPCRF, particularly in the areas of clinical performance and patient care results. HCQIP has resulted in a transition from the individual case review to looking at large numbers of cases and observing processes by which care is delivered. Approximately 85% of Missouri hospitals have now participated with MPCRF in at least one HCQIP project.

Richard Bradley, MD, then gave the report on MOMEDICO. He reported MOMEDICO has over the

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years been able to close some 82% of the claims which were presented to it without payments to any plaintiff or plaintiff's attorney. In addition, when cases did go to trial, they won three out of four. MOMEDICO is working with a company in Alabama known as Mutual Insurance.

Dr. R
Dr. O'Sullivan
MISSOURI

Sandra Mitchell, AMA Alliance President, brought greetings from more than 55,000 Alliance members nationwide.

Dr. O'Sullivan then appointed the following members to the Committee on Nominations:

District 1	James Conant, MD, *St. Joseph*
District 2	Sandra Ahlum, MD, *Hannibal*
District 3	Octavio Chirino, MD, *St. Louis*
District 4	Jeffrey Copeland, MD, *St. Charles*
District 5	Kenneth Rall, MD, *Independence*
District 6	Phillip Hornbostel, MD, *Sedalia*
District 7	Robert T. Gibbons, Jr., MD, *Overland Park, KS*
District 8	Norman P. Kowlton, MD, *Springfield*
District 9	Edward Jenkins, MD, *Waynesville*
District 10	Mel Kasten, MD, *Cape Girardeau*
OMSS	Peggy Barjenbruch, MD, *Mexico*
MSS	Janine Maere, *St. Louis*
RPS	Sam Page, MD, *St. Louis*

The House stood for a moment of silence to honor physicians who died since the last meeting. These members' names appear on page 289.

After moving the late resolutions to the consent calendar and then to the Reference Committees, the first session was adjourned by Vice Speaker Rollo.

SECOND SESSION

The second session of the House of Delegates was called to order by Vice Speaker Rollo at 4 p.m., Friday, April 11, 1997.

Dr. Rollo then called upon Charles Van Way, MD, to give the Supplemental Report of the Committee on Credentials. Dr. Van Way reported the following number of members presented satisfactory credentials, constituting the roll call of the 1997 Annual Convention of the House of Delegates: nine officers, 31 councilors and vice councilors, and 159 delegates. The report was adopted.

Vice Speaker Rollo announced that Congresswoman Karen McCarthy was in attendance. She addressed the Delegates and welcomed them to Kansas City.

The AMA Alliance Report was given by Sandra Mitchell, AMA Alliance President. She brought greetings from the more than 55,000 Alliance members nationwide.

Dr. O'Sullivan then presented legislative awards to Senator Sam Graves, Tarkio; Senator Joe Maxwell, Mexico; Representative Tim Harlan, Columbia; and Representative Charlie Shields, St. Joseph. They were honored for having partnered with medicine; paving the way for better health care in Missouri.

Dr. O'Sullivan presents a legislative award to Representative Charlie Shields from St. Joseph.

Vice Speaker Rollo called upon Octavio Chirino, MD, to present the Nominating Committee appointments:

President-Elect	Stephen Vilmer, MD
First Vice President	Phillip Hornbostel, MD
Second Vice President	R. John Torontow, MD
Third Vice President	Jo-Ellyn M. Ryall, MD
Speaker	Frederick DeFeo, MD
Vice Speaker	John Rollo, MD
AMA Delegates	Robert T. Gibbons, Jr., MD William Huffaker, MD H. Peter Ekern, MD David Barbe, MD
Alternate Delegates	H. Jerry Murrell, MD Mr. Rich Sipes Mark Kasten, MD James Wolfe, MD

The nominations were then closed and it was announced they would be voted on Sunday at the Third Session.

Reference Committee A Members: William Haynie, MD; Mina Bradford, MD; Steve Buie, MD, Chair; and Kathy Lentz, MD. Not Pictured: Octavio Chirino, MD.

Reference Committee A

Octavio Chirino, MD, of St. Louis, presented the report of Reference Committee A. The following items were placed on the consent calendar:

1. *Report of Committee on Constitution & Bylaws*
2. *Report of Committee on Continuing Medical Education*
3. *Report of Commission on Continuing Education & Health Manpower*
4. *Report of Missouri State Medical Foundation & financial statement*
5. *Report of Missouri Physicians Health Committee & financial statement*
6. *Report of Commission on Interspecialty Medicine*
7. *Report of MSMA Peer Review Consultant System*
8. *Report of Missouri State Medical Services, Inc. & financial statement*

The consent calendar was adopted by the House. The Committee then made recommendations on the following resolutions:

Resolution #1 "Offering Medical Savings Account MSA(s) as an AMA Member Program"

Action: **Adopted**

RESOLVED, that the AMA Board of Trustees direct its AMA Insurance Company in all due haste to further investigate and offer Medical Savings Account to AMA members and their employees, and be it further

RESOLVED, that the Missouri delegation sponsor this resolution to the AMA House of Delegates (A-97) meeting.

Resolution #2 "Opening a Dialogue with the Legal Profession on ERISA"

Action: **Adopted**

RESOLVED, that in addition to seeking legislative modification of ERISA, AMA policy should include other methods of affecting change in ERISA, and be it further

RESOLVED, that AMA open a dialogue with national and state legal associations, insurance commissioners' associations, and judicial organizations on ERISA modifications, and be it further

RESOLVED, that this dialogue should include a mutual exchange of information, joint participation at conferences, etc., so that common ground can be found for the medical and legal professions to work together to bring about change in ERISA, and be it further

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RESOLVED, that this resolution be submitted to the AMA House of Delegates by the Missouri delegation at the A-97 meeting.

Amended Resolution #4 "MSMA Provide Consumers with an Annual Health Plan Expenditure Summary on all Licensed HMO's in Missouri"

Action: **Adopted**

RESOLVED, that MSMA publish yearly expenditure summaries on health insurers in Missouri similar to the California Medical Association's third annual *Knox-Keene Health Plan Expenditure Summary* and release it as a press release on an annual basis.

Arthur Gale, MD, addresses Reference Committee B members while Arturo Montes, MD, waits his turn.

Resolution #5 "Formation of MSMA International Medical Graduate (IMG) Section"

Action: **Adopted**

RESOLVED, that the Missouri State Medical Association act to form a Section for International Medical Graduates based on voluntary membership and guided by a statement of purpose which would include elements such as:

- enhancing IMG participation in organized medicine;
- enhancing state and local outreach, communication, and interchange with IMGs;
- promoting membership growth at the local and state level;
- providing for focused representation of IMG's views in organized medicine;
- offering information and education.

Amended Resolution #6 "Assessment of Missouri Physicians' Educational Needs on Osteoporosis"

Action: **Adopted**

RESOLVED, that MSMA in affiliation with the Missouri Osteoporosis Foundation conduct an assessment of Missouri physicians' attitudes and educational needs on advances in the science of preventing, diagnosing, and treating osteoporosis, and be it further

RESOLVED, that MSMA evaluate these data to determine what, if any, educational courses about these new advances in preventing, diagnosing, and treating osteoporosis may be desired by the physicians in Missouri.

Substitute Resolution #7 "Protect Prescriber from Fraudulent Use of DEA Number"

Action: **Adopted**

RESOLVED, that MSMA request AMA to develop model legislation to outlaw the practice of requiring DEA numbers for non-controlled substance prescriptions, and be it further

RESOLVED, that this legislation outlaw the sale or release of DEA number data to non-governmental entities, and be it further

RESOLVED, that this legislation outlaw the use of DEA number data to track prescription histories of physicians for commercial use.

Resolution #8 "National Practitioner Data Bank, Request for Self Inquiry"

Action: **Referred to Council**

RESOLVED, that the Missouri State Medical Association contact the C.E.O. and/or the Medical Director of every medical insurance company and managed care organization in the State of Missouri to educate them about their rights ... or lack thereof ... to obtain information from the NPDB as delineated in the Health Care Quality Improvement Act of 1986, and be it further

RESOLVED, that MSMA remind its members that they are not obligated to self query the NPDB and provide information in their files to any managed care organization or other health care entity, and should safeguard the information contained in their NPDB files by insuring that any organization that requests the information guarantees it will keep the information confidential and not release it to any other individual or organization without the express written permission of the physician; and be it further

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RESOLVED, to inform the Director of the Division of Insurance for the State of Missouri of this present practice in the marketplace for possible investigation of companies which make inappropriate requests for NPDB information, and/or do not take steps to insure its confidentiality.

Resolution #9 "Termination of the Physician-Patient Relationship"

Action: **Referred to Council**

RESOLVED, that the Missouri State Medical Association notify the C.E.O. and/or medical director of every managed care organization in the state to inform them that patients should have the right to choose their own physician, and physicians have an ethical right to exercise individual medical judgment concerning whether or not to continue a given physician-patient relationship, and be it further

RESOLVED, that the MSMA ask the Director of the Division of Insurance for the State of Missouri to investigate and take action against any managed care organization which attempts to enforce a policy which would prevent a physician from exercising his or her right to terminate the physician-patient relationship whenever the physician believes it is appropriate to do so.

Substitute Resolution #18 "Errors in Billing"

Action: **Adopted**

RESOLVED, that any physicians accused of fraudulent billing should not be publicized or punished until proceedings are finalized, and be it further

RESOLVED, that the Board of Healing Arts continue to avoid taking action against a physician's license until proceedings are finalized.

Substitute Resolution #20 "Pain Management"

Action: **Adopted**

RESOLVED, that MSMA encourages the cooperation of Missouri Physicians, the State Board of Pharmacy, State Board of Registration for the Healing Arts, and the BNDD to:

1. disseminate guidelines for acceptable pain management, including standards for assessing pain in patients and responding to that pain with appropriate education and pain management;
2. facilitate dissemination of information regarding guidelines and protective legislation which already exist;
3. foster cooperation among regulatory groups to assure consistency and fairness in patient care and to lower barriers to access from regulatory agencies and payor groups; and
4. cooperate in developing educational resources for the professionals, regulators, insurers, health care facilities and patients.

Amended Resolution #22 "Hospital-Insurer Mergers"

Action: **Adopted**

RESOLVED, that the MSMA provide its members liaison with the Missouri Attorney General and the

Continued on page 260

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Insurance Director on matters of alliances of payers and providers, conversions of not-for-profit to for-profit entities and mergers involving payers, insurance companies, and hospitals, and be it further

RESOLVED, that the MSMA represent physician and patient concerns to the Missouri Attorney General and Insurance Director in reviewing proposals that involve transfer of assets, alliances, acquisitions, and/or mergers of integrated health care delivery and financing systems where hospitals might take on the responsibility of acting as both health care providers and insurers, and be it further

RESOLVED, that the MSMA would oppose any proposals which would unreasonably restrain competition.

Resolution #23 "Board Certification and Residency Training Requirements in Primary Care"

Action: **Referred to Council**

RESOLVED, that the position of MSMA is that hospitals should use neither board certification nor residency training as a prerequisite for obtaining hospital privileges in primary care medicine, and be it further

RESOLVED, that MSMA will seek legislative relief prohibiting Missouri hospitals from denying hospital privileges to primary care physicians solely because they either did not complete a residency or are not board certified.

Resolution #27 "Internet Connection Equality"

Action: **Not Adopted**

RESOLVED, that the MSMA afford all MSMA members the opportunity to subscribe to an Internet Service at the same rate as MoMed Net.

Resolution #28 "Diabetes Education for Medicaid Patients"

Action: **Referred to Council**

RESOLVED, that the MSMA work with the Missouri Department of Social Services to obtain payment for diabetes education by Registered Nurses, and dietary instruction by Registered Dietitians who are Certified Diabetes Educators, and be it further

RESOLVED, that the MSMA work with the Missouri Department of Social Services to obtain payment for diabetic education provided by those programs which have recognized status by the American Diabetes Association.

Resolution #29 "Home Blood Glucose Monitoring for Medicaid Patients"

Action: *Adopted*

RESOLVED, that the MSMA will work with the Missouri Department of Social Services to lift the requirement for a Medicaid Exception Request and allow a written prescription be sufficient documentation for Medicaid patients to obtain a blood glucose meter every three years and blood glucose test strips as needed.

Substitute Resolution #30 "Cuts in Medicare and Medicaid Reimbursement"

Action: **Adopted**

RESOLVED, that MSMA and AMA urge Medicare and Medicaid insurers to provide adequate reimbursement that reflects actual practice costs.

Reference Committee B Members: Richard Gimpelson, MD, Chair; Ed Masters, MD; Barbara Buchanan, MD; and Ken Rall, MD. Not pictured: Hal Lurie, MD.

Reference Committee B

Richard Gimpelson, MD, of Chesterfield, presented the report of Reference Committee B. The following items were placed on the consent calendar:

1. *Report of the President, MSMA Alliance & Committee on Legislative Affairs*
2. *Report of the Secretary*
3. *Report of the Treasurer & financial statement*
4. *Report of the Executive Vice President*

5. *Council Minutes*
6. *Report of Commission on Medical Economics, Third Party Medicine & Governmental Relations*
7. *Report of Commission on Medical-Legal Affairs*
8. *Report of Commission on Public Affairs*
9. *Report of Committee on Publications*
10. *Report of MSMA Health Education Foundation & financial statement*

The consent calendar was adopted by the House. The Committee then made recommendations on the following resolutions:

Substitute Resolution #3 and #15 "Proposed Legislation to Increase Missouri Excise Tax on Tobacco Products"

Action: **Adopted**

RESOLVED, that MSMA pursue the forty cent increase in Missouri's excise tax on cigarettes with at least half of the proceeds earmarked for a public education program to counter the effects of advertising that has influenced young people to begin and continue using tobacco products, and be it further

RESOLVED, that a portion of those proceeds be earmarked to encourage local cities and counties to pass laws requiring retailers to purchase a license to sell cigarettes, and if they repeatedly sell cigarettes to minors they will lose that license, and be it further

RESOLVED, that the MSMA Legislative Committee and Council be given the flexibility to pursue the most politically expedient avenue to accomplish these goals, and be it further

RESOLVED, that MSMA oppose any proposed preemption clauses that would restrict the ability of local governmental bodies to pass laws on the subject of tobacco and cigarettes.

Resolution #10 "Policy on Contributions to MSMA Members' Campaigns for AMA Elective Office"

Action: **Adopted**

RESOLVED, that the following shall be the guiding policy for making monetary contributions to Missouri State Medical Association members' bids for elective office in the American Medical Association.

A Missouri State Medical Association member who is interested in running for elective office in the American Medical Association shall:

1. Discuss his or her candidacy with the Missouri delegation to the AMA. The delegation will consider the candidate's qualifications and electability, and will vote to approve or reject support for the candidacy.
2. If the Missouri delegation recommends support for the candidate, the chairman of the delegation will present the recommendation in his or her report at the next Council meeting. If the Council accepts the recommendation to support the candidate, the candidate shall meet with the ad hoc panel consisting of the MSMA President, President-Elect, Treasurer, the chairman of the Missouri AMA delegation, and the MSMA staff to discuss financing for the campaign.

- The candidate should be prepared to discuss campaign contributions available from his or her national and state specialty societies, his or her component medical society and hospital medical staff, and his or her personal funds.
- Following this meeting, a campaign budget will be developed. The limits on MSMA contributions shall be $20,000 for campaigns for a Board of Trustees seat, and $10,000 for campaigns for AMA Council seats.

3. The ad hoc review panel shall make a dollar-amount recommendation for inclusion in the full Missouri State Medical Association budget (which is considered and discussed at the December Council meeting).
4. The ad hoc panel shall discuss with the candidate the number of times MSMA will contribute to his or her campaign(s). Realistically, a candidate who has received Association support in a successful race would probably continue to have MSMA support in his or her subsequent bids for reelection, up to AMA term limitations. Additionally, a candidate may choose to run for a different office in a subsequent year, the panel shall discuss these options with individual candidates as appropriate.
5. The name of the MSMA candidate, the AMA Office or Council seat he or she is seeking, and the amount of the MSMA's contribution to the campaign shall be published in *Missouri Medicine*.

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6. Following the election, the candidate shall submit a complete accounting of his or her expenses to the Council.

Amended Resolution #11 "Gatekeeper Referral to Psychiatrists"

Action: **Adopted**

RESOLVED, that MSMA support legislation that would allow gatekeeper systems to refer patients with psychiatric symptoms directly to psychiatrists for assessment and triage.

Substitute Resolution #12 and #13 "Uncompensated Medical Care Provided by Trauma Centers"

Action: **Adopted**

RESOLVED, that the Missouri State Medical Association form a representative committee to address and make recommendations to the MSMA Council on at least the following trauma care issues:

- petition the state to enact legislation that would add an additional fine to individuals connected with crime closely related to trauma;
- money received from this additional fine would be utilized to help defray some of the financial burden due to uncompensated trauma care;
- a system ensuring equitable distribution of this money to participating trauma centers should be established;
- early transfer of trauma patients to non-trauma centers at the request of third party carriers;
- petition the state to enact legislation that insurance programs consider at least a Level II trauma center in their group of participating hospitals;
- education of the various insurance companies on the unique problems and needs of the trauma patient and trauma center.

Substitute Resolution #14 "Primary Enforcement of Seatbelt Laws"

Action: **Adopted**

RESOLVED, that the Missouri State Medical Association encourages the General Assembly to enact legislation that would allow primary enforcement of safety belt laws and prohibit riding in the open beds of pickup trucks.

Resolution #16 "Screening of Hemochromatosis"

Action: **Adopted**

RESOLVED, that the Missouri State Medical Association encourages all physicians and health plans to include screening for hemochromatosis as a part of routine preventive care, and be it further

RESOLVED, that the Missouri State Medical Association encourages the General Assembly to enact legislation that would protect hemochromatosis patients and all patients with genetic disease from employment and insurance discrimination on the basis of genetic information.

Resolution #17 "Medical Liability"

Action: **Referred to MSMA Legislative Committee**

RESOLVED, that physicians should be indemnified for medical legal liability if acting in good faith, and be it further

RESOLVED, that this resolution be forwarded to the MSMA Legislative Affairs Committee and the state of Missouri, and be it further

RESOLVED, that this resolution be forwarded to the Annual meeting of the AMA House of Delegates in June 1997.

Resolution #19 "Managed Care Reimbursement"

Action: **Referred to Council**

RESOLVED, that HMO, PPO, PHO, Managed Care, etc., should allow patients to seek medical care, (physicians, hospitals) outside their program, and be it further

RESOLVED, that the patient should be covered, reimbursed according to their program and not penalized if they seek medical care outside their program, and be it further

RESOLVED, that the patient be given the right to choose and have access to their medical care provider, and be it further

RESOLVED, that this resolution should be forwarded to the MSMA Committee on Legislative Affairs and to the Annual Meeting of the AMA House of Delegates in June 1997.

Substitute Resolution #21 "Proposed Legislation to Address Abuses by HMO's and PPO's"

Action: **Adopted**

RESOLVED, that the MSMA suggest qualified counselors to represent its members in contract negotiations with insurance companies, and be it further

RESOLVED, that MSMA develop guidelines for physician/insurer contracts that protect patient care and physician autonomy, and facilitate access to this information for MSMA members, and be it further

RESOLVED, that MSMA seek to implement a member service whereby the standard physician contract(s) used by major Missouri health care insurers be regularly reviewed by legal counsel in a generic fashion and that the results of such review be available to MSMA members at low or no cost, and be it further

RESOLVED, that the MSMA widely publicize this member benefit.

Substitute Resolution #24 and #25 "AMA Develop a Strategy for Eliminating Delayed Payments to Physicians by Third Party Payers"

Action: **Adopted**

RESOLVED, that the American Medical Association develop and implement a plan to inform legislators, media, state insurance commissioners, state and national attorneys general, Federal regulators, patients, and the general public about the unethical practices of third party payers whereby they delay payments to physicians and hospitals, and be it further

RESOLVED, that the AMA draft and propose legislation at both the national and state levels based on the successful Maryland law which would eliminate the problem of delayed payments by third party payers to physicians and hospitals, and be it further

RESOLVED, that the MSMA introduce a law in the next Missouri state legislative session requiring third party payers to pay 1½% interest per month on overdue bills when delaying timely payment of claims provisions to physicians.

Resolution #26 "Standardization and Availability of MCO Enrollment and Benefit Reports"

Action: **Resolveds #1 and #2 Referred to Council; Resolveds #3, #4, and #5 adopted.**

RESOLVED, that managed care insurance companies doing business in Missouri be required to sponsor semi-annual meetings, where physicians and their staffs can be informed about plan enrollment and benefit structure, and be it further

RESOLVED, that the semi-annual meeting will include meaningful discussion and good faith efforts to standardize policies and procedures among plan benefit structures and claims payment practices, and be it further

RESOLVED, that managed care insurance companies doing business in Missouri be required to provide monthly reports to individual medical offices that contain the following information on patients cared for by the medical practice: patient names, identification numbers, plan numbers, deductibles, copayments, lifetime maximum status, and a reference to eligible benefits, or if the physician agrees, the managed care company may provide a computer-assisted data base, accessible by telephone modem, that contains the same, frequently updated information, and be it further

RESOLVED, that the format, content, and other important matters concerning these required activities be approved by the Department of Insurance, with input by the Missouri State Medical Association and the managed care industry, and be it further

RESOLVED, that the state will conduct an annual survey of licensed Missouri physicians in order to "provider-rate" each insurance plan over a broad range of standardized parameters including: administrative fairness and friendliness, provision and payment of benefits, communication effectiveness, and other items. This survey will be developed with the assistance of organized medicine and the results published widely to patients, employers insurers, and the government.

Speaker DeFeo reminded the House that there was a proposed constitution and bylaw change, enacting the recommendation to set up an international medical

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graduate section. The constitutional change could not be voted on at this convention, but the bylaws change would be voted on at the Third Session.

James Conant, MD, St. Joseph, was the winner of a Cassiopeia compatible desktop computer from the exhibit drawing.

Speaker DeFeo then adjourned the Second Session of the House of Delegates 1997 Annual Convention.

Candace Keller, MD, a member of the AMPAC Board of Directors, presents Mel Kasten, MD, MSMA MMPAC Committee Chair, with the 1996 AMPAC Membership Award.

THIRD SESSION

The third session of the House of Delegates was called to order by Speaker DeFeo at 7:30 a.m., Sunday, April 13, 1997.

Dr. DeFeo then called upon Charles Van Way, MD, to give the Supplemental Report of the Committee on Credentials. Dr. Van Way reported the following number of members presented satisfactory credentials, constituting the roll call of the 1997 Annual Convention of the House of Delegates: nine officers, 32 councilors and vice councilors, and 181 delegates. The report was adopted.

Speaker DeFeo then called on Dr. O'Sullivan to present the President's Award. He presented the award to David Wilkinson, MD, from St. Louis.

Octavio Chirino, MD, Nominating Committee Chair, submitted the recommendations of the Nominating Committee. These are reported in the Second Session of the House of Delegates. The position of AMA Alternate Delegate was contested. The two candidates were Mark Kasten, MD, and James Wolfe, MD.

Donald Fakhoury, MD, introduced and nominated Stephen Vilmer, MD, as President-Elect. Dr. Fakhoury spoke of Dr. Vilmer growing up in Kansas City and attending Kansas University. He completed an internship in California and his residency at the prestigious Dixon and Dively Clinic in Kansas City. After serving two years in the Navy, Dr. Vilmer came to practice orthopedic surgery with his father in Kansas City. He is on staff at three hospitals and has served on many positions at these hospitals. He has also served Clay County Medical Society well and has been a councilor within the Association. Dr. Fakhoury reminded the Association that the Clay County Medical Association is the second oldest association west of the Mississippi and this is the first time in 50 years they are nominating the President-Elect.

Dr. Vilmer is married to Gayle Gregory. She is a member of the MSMA Alliance and has served as President.

Jerry Meyer, MD, from the 6th District, and Gary Dyer, 1st District, seconded the nomination for Dr. Stephen Vilmer.

Dr. Vilmer was then elected by acclamation by the House of Delegates. He then thanked them for the honor to continue serving the Association and introduced his wife, Gayle.

The rest of the Officers and AMA Delegates were then elected as presented by the Nominating Committee during the Second Session.

AMA Alternate Delegates Jerry Murrell, MD, and Mr. Rich Sipes were elected by acclamation while the position to fill the expired term of David Barbe, MD, was contested by James Wolfe, MD, and Mark Kasten, MD. After a presentation by each candidate and a secret vote, Dr. Wolfe was announced as the Alternate AMA Delegate.

The following members were elected Councilors and Vice Councilors:

District 1
Councilor .... Robert Schaaf, MD
Vice Councilor .... Stephen McCray, MD

District 2
Councilor .... Carl Kruse, MD
Vice Councilor .... Lent Johnson, MD

District 3
Councilors .... Gordon Goldman, MD
Robert Miller, MD
Arturo Montes, MD
Meredith Payne, MD
Vice Councilor .... Octavio Chirino, MD

District 4

Councilor .... Sam Farrell, MD
Vice Councilor .... Jeffrey Copeland, MD

District 6

Councilor .... Jerry Meyer, MD
Vice Councilor .... Phillip Hornbostel, MD

District 7

Councilor .... Linda Dorzab, MD

District 8

Councilor .... Clarence Martin, MD
Vice Councilor .... Michael Hoeman, MD

District 10

Councilor .... Mark Kasten, MD
Vice Councilor .... Thomas Hartman, MD

Organized Medical Staff Section

Councilor .... Luis B. Anglo, MD
Vice Councilor .... Peggy Barjenbruch, MD

Resident Section

Councilor .... Mary Vest-Mason, MD
Vice Councilor .... Jordan Page, DO

Medical Student Section

Councilor .... Kamram Chaudhary
Vice Councilor .... Patricia Anderson

Vice Speaker Rollo directed unfinished business from the previous meeting of the House of Delegates. After discussion about the International Medical Graduate Section, the proposed Constitution and Bylaws changes were approved.

Norman Knowlton, MD, MSMA Secretary, then installed the Officers, Councilors, Vice Councilors, AMA Delegates, and Alternate Delegates.

Vice Speaker Rollo called President A.J. Campbell to give the President's Appointment of Committees and Commission Chairs. Dr. Campbell announced the following Committee and Commission appointments:

Committee on Constitution & Bylaws
Donald Potts, MD, *Kansas City*

Committee on Physicians Health
Thomas Anderson, MD, *Columbia*

Committee on Planning
Herluf Lund, Jr., MD, *St. Louis*

Committee on Publications
J. Regan Thomas, MD, *St.Louis*

Committee on Legislative Affairs
Robert N. Miller, MD, *St. Louis*

Commission on Continuing Education & Health Manpower
David S. Martin, MD, *Chesterfield*

Commission on Medical Economics, Third Party Medicine & Governmental Relations
Phillip Hornbostel, MD, *Sedalia*

Commission on Legal Affiars
Marc Taormina, MD, *Independence*

Commission on Public Affairs
Ann L. Peick, MD, *Poplar Bluff*

Council on Ethical & Judicial Affairs
Hugh E. Stephenson, Jr., MD, *Columbia*

Commission on Interspecialty Medicine
Mark Martin, MD, *Lee's Summit*

President Campbell added that the term of Ronald Youmans, MD, on the Council on Ethical and Judicial Affairs expires in 1997. He then nominated Frederick Hahn, MD, Independence, for this five-year term. The nomination was approved.

Carl Petit, MD, made a motion that the MSMA hold the 144th Annual Convention in 2002 at the Lake of the Ozarks.

Following the passing of the motion Vice Speaker Rollo announced the winner of the second exhibit drawing as Donald Fakhoury, MD, of Concordia. The winner of the $100 cash giveaway from the Medical and Claims Director Book was Raul Borrego, MD, of Farmington. After announcing the state of Missouri as the new pin design, Vice Speaker Rollo declared the 139th Annual Convention of the House of Delegates adjourned. **MoMed**

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Excerpts of Dr. Corlin's Address to the House of Delegates

Richard Corlin, MD, was the featured speaker. Dr. Corlin is the Speaker of the House of Delegates of the AMA.

We do live in interesting times. The Chinese proverb is exactly right for us. Perhaps these are more unsettled and more rapidly changing and evolving times than any other. I think we need to keep up with this rate of evolution.

Nobody knows what our health care delivery system is going to look like in the near future except to say that given the changes that have gone on in the last 10 or 15 years, in our health care delivery system, in this country, it is obvious evolution is not going to suddenly stop it from changing. It is going to keep changing.

It is important for us to maintain that role of monitoring and guiding and influencing the change in our patient's best interests because, as we all know, there are people out there who are doing these changes not in our patients' best interests.

There are pluses and minuses in coming from California. Obviously, we are all aware of all of the California jokes and I think most of them are exactly correct. The one thing I will say is that if you consider the fact that California elected consecutively as governor first Ronald Reagan and then Jerry Brown, it's obvious that we are 30 million people with a collective identity crisis.

But one of the things that I can tell you about is what it's like to live with managed care as fully developed as we have it.

I have a six-person gastroenterology group. I am the senior physician in that group. Until I got active in the AMA, I was the number one producer of the group. I am now the number six producer in the group.

We have a practice in a carriage trade area. We have about 75 percent managed care. Now that Medicare managed care is coming in, we anticipate going to probably 85 or 90% managed care. That doesn't mean 85 or 90% HMO. But it means managed care in one form or another.

I think it's obvious to us that managed care is clearly here to stay. I think HMO's are clearly here to stay as a picture of it. I don't believe that for-profit HMO's are here to stay as a permanent fixture of it. I think that is one of the areas that we will see the most rapid change.

If you go back to the 1973 HMO Act, which was passed during the Nixon administration, and take a look at what was intended, what was intended was something modeled after the Kaiser organization, not-for-profit HMO's in which physicians had major influence in the policymaking of the organization. A for-profit HMO was an aberration that wasn't really considered at the time.

If you take a look at what has happened since then, there is what I refer to as the target du jour in Washington. First, the target du jour was the hospitals because they had all the money. Then in 1986, as part of an act passed by Congress, before profit hospital chains were largely wiped out, and they were wiped out by two simple lines in that act that said when Medicare is the payer, a for-profit hospital will no longer receive return on equity or its profit from Medicare.

So if the for-profit hospital had a 6% bottom line profit, they had to rebate 6% of it back to the government. The private payers rapidly followed suit.

If you remember back to those days, it was stated that AMI, Humana, and a couple of others were going to take over the entire hospital landscape. Most of those chains are virtually gone now. Some of their former CEO's are probably up for parole in the next two years.

Then it became physicians as the target du jour, because when they had wiped out the profit from hospitals, the money being made by physicians was the item the public press concentrated on and changes were made and changes are being projected in the next couple of years to take money away from physicians.

Then it became evident that the big money in medicine was the profit made by the for-profit HMO's. Leonard Abramson selling U.S. Healthcare to Aetna and walking away with $900 million was something that enraged people in Congress and we rapidly saw anti-HMO legislation come through.

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I think what we will see is a legislative attempt to say not just when a for-profit hospital is paid by the government, but when a for-profit hospital or health plan is paid by the government, while HMO's will remain, the for-profit element will not.

If you really consider it, that's what it should be. I am not here to either defend or attack HMO's, but if an HMO exists, who should it exist for the benefit of?

It should exist for the benefit, to be sure, of the people who pay the premium. Mainly, it should exist for the benefit of the patient, and it should exist for the benefit of the medical community so that we can deliver care more efficiently.

There is no compulsion that we have to defend the rights of the stockholders of the HMO's. Those are the people whose rights I put last on the list and who have no right to be defended. I think that is where we will see the attack in the future.

One of the things the AMA is concentrating on now, and I was in Washington two weeks ago and will be there again to testify in another two weeks, is the advent of PSO's, physician sponsored organizations, which basically will be primary insurance writing organizations.

We need some federal legislation to allow us to get in that business, bypassing the intermediate element, whereby a physician group and a local hospital network can directly commit to providing the care without having an insurance company involved. We need some help in dealing with reserve issues and a couple of others.

It is very interesting. When I testified before Congress we had three principal opponents in the testimony: insurance companies, HMO's, and the Blues. We carried the day and we carried the day because our position was truly in the patients' best interest.

Both the Republicans and the Democrats on the committee sided with us. The reason they did was the testimony we gave that said it's amazing insurance companies that advocate competitive environment are here lobbying against competition, and HMO's and the Blues, which 20 years ago went to Congress for some special exemptions to allow them to get started in a niche of the environment of insurance with reduced reserves, could argue against other people wanting the same exact thing.

That was a position they couldn't answer or respond to. As a result, we carried both sides of the committee.

I would urge you to pay specific attention to the PSO issue as it comes up. Specifically, each one of you get *AM News* every week. Spend 10 or 15 minutes reading it. Particularly pay attention to the items related to PSO's, because they are going to be very, very important bits of legislation later this year. We can't afford to be uninformed.

The other issue that we are dealing with in Medicare is the government's attempt to completely restructure the practice cost component of Medicare. Now we all know we may have to give back some money in the Medicare program. So what if you have to give back a few percentage points here or there to make the system work right. That is not going to fundamentally change who we are. But what we do have a right to demand is honesty, integrity, and logic.

I pride myself on being pretty quick with numbers, being good at math, and liking math games and puzzles. I sat in on a three-hour briefing for the new proposed formula for physician office practice expense component of the Medicare payment. I can tell you after three hours of listening to that briefing, I don't have the slightest clue what they're trying to do. It is the most arcane and absurd proposal that I've ever heard. Not because I disagree with it, not because I don't like it, but because it doesn't make any sense. That's the problem we face.

What our approach is gong to be is, yes, we are willing to contribute with everybody else in keeping the Medicare system solid. We recognize we have got to do that. But we demand it be based on logic and based on integrity, and be based on fairness. That is not the approach they are taking.

The AMA's first tack is to say, do not implement it January 1, 1998. Wait a year until we can get some data. Because they don't have any good data to work on. That is another issue I would urge you to spend a lot of time and attention dealing with when you get *AM News*.

The final two points I would like to make are we ascribe all of the changes that have gone on to managed care. Well, managed care has caused some of them, to be sure, but managed care has not caused most of the changes we've seen.

Most of the changes we are seeing in our practice I believe are due to two things: One, is advancing technology. That, more than anything else, is changing things. It reduced the need for hospital beds. It wasn't managed care. Gallbladders would have gone to outpatient procedures. Deliveries from five days to one.

When I was 14-years-old I had a summer job as a hospital orderly. Treatment of an MI was six weeks in the hospital. All of these technologic changes pulled the need out for hospital beds and technologic changes are affecting medical practice as well–as are the manpower issues.

The physician work force issue with the surplus of physicians in most specialties, in most areas, has impacted our practices more than anything else. The federal government has finally begun to realize just as the surplus of hospital beds drives up the cost of medical care, so, too, does the surplus of doctors drive up the cost of medical care.

Physicians are not like canned corn. When you have a bumper crop and there is too much canned corn the price of canned corn drops because there is only so much canned corn the people are going to buy.

Medical care needs are insatiable. As you put more physicians into the work force above and beyond the need, they are absorbed to greater utilization. We need to take a good look, and for the first time we have the government's intention to appropriately look at the work force size within the physician community.

So we are paying attention to these things and I would urge you to.

Finally, I am not a gloom or doom person. I don't think we are in for an era of devastation or terrible events within the practice of medicine. We may lose a few percentage points in the reimbursement, but that is not going to fundamentally change who we are, what we do, or our approach to our profession.

I am disappointed when I hear some physicians say, "I would never want one of my children to be doctor any more." I have two three-day-old sons and if they both became physicians that would be one of my greatest joys. It's something I went into, not for the money, because when I started in physicians were not wealthy people. Physicians only became wealthy after Medicare. The reasons I went into medicine are still there and they still will be there for all of us. I think we need to remember that.

One of my favorite quotes, and I would like to close with this, is a line that Stephen Padgett wrote in 1826. As we get involved in all of the politics and everything we are here to deal with the business of, I think it's something else that we need to remember. What Stephen Padgett wrote: "If a physician's life may not be a divine vocation, then no life is a vocation and nothing is divine." Thank you very much. MoMed

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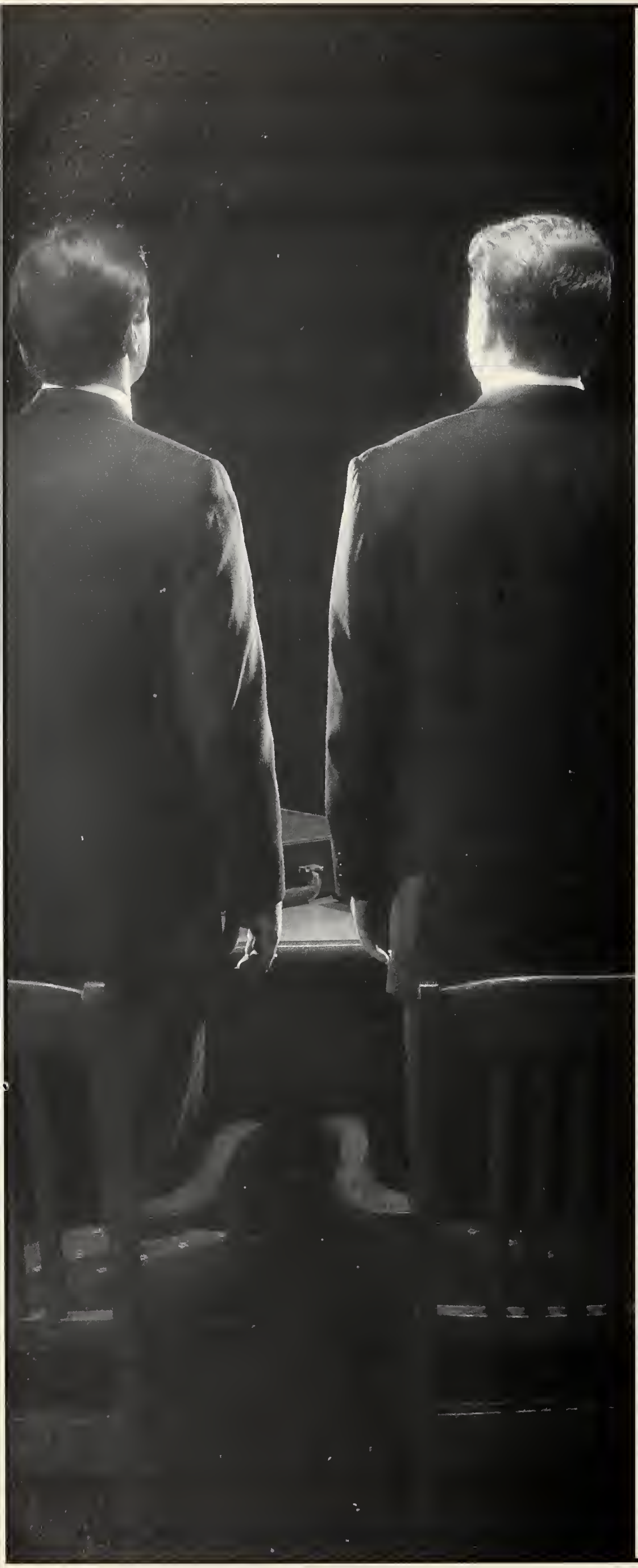

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President's Report - see page 245
MSMA Alliance Report - see page 293
Report of Treasurer - Financial Statements, March *Missouri Medicine*

Report of Secretary

The Missouri State Medical Association had 5,449 members as of the December 1996 audit. This was a net loss of 211 members from our membership of 5,660 on the December 1995 audit. Following is a breakdown according to classification.

Year	Students	Residents	Active	Honor	Total
1995	370	206	4,065	1,019	5,660
1996	317	154	3,928	1,050	5,449
	-53	-52	-137	+31	-211

Number of member deaths reported during 1996 totaled 68.

President-Elect to fill the expired term of A.J. Campbell, Sedalia.

Three Vice-Presidents to fill the expired terms of David Wilkinson, St. Louis; Wilfred Wooldridge (deceased), Springfield; and Robert T. Gibbons, Jr., Overland Park, KS.

A Speaker and Vice-Speaker of the House of Delegates to fill the expired terms of Frederick DeFeo, Speaker, Kansas City and John Rollo, Vice-Speaker, St. Louis. Both are eligible for re-election.

Three Delegates and Three Alternate Delegates to the AMA to fill the vacancies created by expiration on December 31, 1997 of the terms of Delegates Robert T. Gibbons, Jr., Overland Park, KS; William Huffaker, Chesterfield; and H. Peter Ekern, Mexico; and Alternate Delegates David Barbe, Mountain Grove; H. Jerry Murrell, Columbia; and Rich Sipes, Columbia. These terms will be from January 1, 1998 to December 31, 1999.

Also need to elect one Delegate to fill the unexpired term of David Hall (deceased), Rogersville. Term to begin April 13, 1997 and expire December 31, 1998.

The terms of the following Councilors expire this year: 2nd District - Carl R. Kruse; Palmyra; 3rd District Gordon Goldman, Robert N. Miller, Arturo Montes, and Meredith Payne, St. Louis; 4th District - Sammy L. Farrell, Washington; 6th District - Jerry Meyer, Concordia; 7th District - Linda Dorzab; Raytown; 8th District - Clarence Martin, Joplin; 10th District - William Shell, Sikeston; Organized Medical Staff Section - Luis B. Anglo, St. Louis; Resident Physicians Section - Mary Vest-Mason, Clayton; Medical Students Section - Ms. Janine Maere, St. Louis. The terms of the following Vice-Councilors expire this year: 2nd District - Lent C. Johnson, Hannibal; 4th District - Jeffrey G. Copeland, St. Charles; 6th District - Phillip Hornbostel, Sedalia; 8th District - Michael Hoeman, Springfield; 10th District - Mark Kasten, Cape Girardeau; Organized Medical Staff Section - Peggy Barjenbruch, Mexico; Resident Physicians Section - Howard Pomenranz, St. Louis; Medical Students Section - Vasu Kakarlapudi, Kansas City, KS. Also need to elect one Vice-Councilor from the 3rd District to fill the unexpired term of Randall E. Treadwell, Chesterfield. Delegates shall meet during the Annual Convention prior to the last day and elect the Councilors and Vice-Councilors for their respective districts and sections. The election shall be certified to the House of Delegates on the prescribed form which will be furnished.

The entire session will be held at the Westin Crown Center Hotel, Kansas City. The House of Delegates will hold its First Session on Thursday, April 10, 10 a.m., Century C; the Second Session is on Friday, April 11, 4 p.m., Century C and the Final Session will convene at 7:30 a.m., Sunday, April 13 in Century C.

Registration facilities will be open on Thursday, Friday and Saturday from 7 a.m. to 4 p.m. Registration will be in the Century Foyer.

Norman P. Knowlton, III, MD

Report of The Executive Vice President

Your Missouri State Medical Association has gone on the offensive on several fronts over the last year.

The Association, with active support from many members, led the way for passage of bills in the 1996 Missouri Legislature that prohibits insurance companies from requiring "drive-through deliveries" and improved statutes on childhood immunizations, underage drinking, anatomical gifts, HIV testing, and several others. Meanwhile, many bills detrimental to patients and physicians were defeated.

The 1997 Missouri Legislature is currently considering measures which would provide patients and providers improved treatment by managed care entities. This legislation is the direct result of earlier efforts by MSMA to introduce and attempt to gain passage of the Patient Fairness Act. Each member is urged to contact their state legislators and express support for the managed care reform bills.

On the Federal level, the Association pushed for passage of the Kennedy/Kassebaum insurance reform bill after first demanding the elimination of fraud language that was discriminating to physicians. Currently, MSMA is working with the AMA and other state societies in an effort to gain true reform in the Medicare program. In the legal area, the Association joined with others to oppose physician-assisted suicide in two cases heard by the U.S. Supreme Court.

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The Association joined two large coalitions in 1996. The Litigation Center is composed of several state associations and the AMA. Funds from each are pooled so that state laws determined to be detrimental to medicine can be challenged in court. Membership fees were also paid to the Geographic Coalition, a group of states where physicians receive lower Medicare reimbursements than the national average. Fairness is being sought.

Meetings: Your Association has continued to increase communications with other groups and has met on several occasions with the Board of Healing Arts, Department of Insurance, Department of Social Services (Medicaid), Missouri Managed Health Care Association, Missouri Association of Osteopathic Physicians and Surgeons, Missouri Hospital Association, Medical Group Managers Association, and Missouri Association of Local Public Health Agencies. President Dr. Daniel O'Sullivan also arranged meetings with Presidents of local medical societies and medical directors of the state's HMO's.

MoMed Net: (http://www.msma.org) is now available and offers members low-cost, unlimited access to the Internet while providing immediate information on key medical issues.

Continuing Medical Education: MSMA's Continuing Medical Education program, which accredits CME programs in Missouri, received the highest accolades possible from the Accredition Council for Continuing Medical Education.

***Missouri Medicine/Progress Notes/Legislative Report*:** Response from members have shown that the Association's publications are increasing their impact and readership due to emphasis on issues that are of direct concern to physicians.

Business issues of the Association include:

Finances: Although the MSMA has the lowest dues of any state medical association and has not increased dues since 1986, your Budget Committee believes our financial condition is sound enough to avoid a dues increase this year. This is primarily due to decreases in expenses and an increase in non-dues income.

Membership: All non-members of MSMA owe dues-paying members a debt of gratitude! Your efforts and participation have made the MSMA the pre-eminent medical organization in our state. Our efforts in the Legislature and with the bureaucracy are highly respected by friends and foes alike. The services and assistance we offer our members and the public are many. This is an organization that members can look to with pride.

However, we must increase membership if the Association is to maintain its strength. Please check with staff at this meeting and review a list of non-members in your area. They are benefitting from your efforts!

Officers and Others: I would like to thank all of the MSMA Officers and Councilors for giving freely of their time and efforts during many weekend meetings year after year. I especially appreciate the dedication of Drs. Daniel O'Sullivan, A. J. Campbell, and Stephen Vilmer in dealing with the many problems that all leaders must tackle.

Staff: Carrying out the directives of this House of Delegates and the Council is the charge of your staff of 12. Those of you who have worked with or sought assistance from staff realize the dedication and expertise they provide to the medical community and to the public. We all owe each of them our sincere appreciation. Along with discharging the directives of the Association, we provide staffing for nine specialty societies, MMPAC, the Physicians Health Program, the Missouri State Medical Foundation and the Missouri State Medical Services. As you enjoy this Annual Convention, take a moment and visit with staff. It will be of benefit to both. Thank you for the privilege of serving!

C.C. Swarens

Summary of 1996-97 Council Minutes

Meeting of April 14, 1996, Lake of the Ozarks

Daniel F. O'Sullivan, MD, President, presided. Norman P. Knowlton III, MD, Springfield, was reelected as Secretary. Edmond Cabbabe, MD, St. Louis, was elected as Treasurer. Stephen Vilmer, MD, Parkville, was elected Chair of the Council, and William Dorzab, MD, Raytown, was elected Vice Chair.

Meeting of June 2, 1996, Lake of the Ozarks

The MSMA Council endorsed the concept of a statewide management services organization (MSO), which was proposed by the Committee to Study a Statewide Managed Care Organization. The Council authorized the MSMS Board of Directors, in consultation with the MSMA Executive Committee, to proceed in establishing an MSO as proposed by the Saint Louis Management Group.

A new category of MSMA membership was approved by the 1996 House of Delegates to benefit those persons who work for MSMA members. Persons approved for Affiliate Membership are eligible for group plans offered by the Association.

MSMA requested Frederick Peterson, MD, the Association's representative to the Medicaid Managed Care Quality Assurance and Improvement Advisory Group, forward the following items for the agenda of the Group's next meeting: lack of electronic billing for Medicaid HMO's, HMO authorization process, slow payment, claim denial after services were verbally authorized, inaccurate published participating physician listings, and noncompliance with access requirements. The MSMA Executive Committee will review action taken by the Advisory Group.

MSMA continued to work with the Department of Health in promoting immunizations. The Council also approved a request to identify 25 physicians who are willing to commit their office staffs to attend the free, day and a half workshops on Clinic Assessment Software Application.

MSMA supports small employers' ability to purchase health insurance through the Missouri Consolidated Health Care Plan and requested Medicaid investigate how Oregon successfully expanded Medicaid eligibility without increasing the cost of the program to the state.

MSMA surveyed Missouri HMO's to identify practice guidelines followed by companies of those covering the same area with results to be made available to MSMA members.

Councilors were appointed to serve as advisors to each respective Commission: Commission on Public Affairs—David Barbe, MD; Commission on Medical Economics, Third Party Medicine, and Governmental Relations—William Shell, MD; Commission on Continuing Education and Health Manpower—Gordon Goldman, MD; Commission on Medical-Legal Affairs—Meredith Payne, MD; Commission on Interspecialty Medicine—Carl Kruse, MD; Missouri Physicians' Health Committee—Edmond Cabbabe, MD.

As of May 6, 1996, 76 noteholders of the MOMEDICO subordinated notes have received a total payment of $166,000. The Council also voted to contribute $4,500 ($1.00 for every active MSMA member) to the AMA State Medical Society Litigation Center.

Richard Heimburger, MD, Osage Beach, was appointed as the MSMA representative to the Department of Health's Subcommittee on Prevention and Control of Resistant Organisms. The Council referred to the Commission on Public Affairs the formation of a speaker's bureau/media response team to respond to media coverage relating to medicine. The Council also approved the following reports: President, Executive Vice President, Missouri State Medical Foundation, Physicians' Advisory Committee on Electronic Communication, MSMA Alliance, Committee on Legislative Affairs, MMPAC, AMA, Councilor Districts, and Medical School Deans.

Meeting of August 24, 1996, Jefferson City

New membership programs and their progress were displayed to the leaders of the MSMA during the August Council meeting. These included: aggressive membership recruitment efforts which incorporate increased mailings, a membership video and one-on-one meetings with nonmembers; promotion of new membership services such as MoMed Net, MSMA Gold MasterCard, and Affiliate Membership; two education pamphlets available for physicians to order: "HIV/ Consent Brochure" and "A Woman's Choice for Breast Cancer Treatment Alternatives;" year-end "Legislative Review" which outlined the progress made toward protecting the practice of medicine in Missouri; MSMA's CME accreditation program which received superior recognition from the ACCME surveyors; improved *Missouri Medicine* content and increased advertising; and development of the Peer Review Consultant program and a statewide credentialing program.

MSMA President, Daniel O'Sullivan, MD, and EVP Cork Swarens met with MOMEDICO officials to formalize the exchange of MSMA's Class C shares to Class A shares.

Dan Jaco of the Missouri Patient Care Review Foundation announced that MPCRF would be signing a new three-year contract. The Foundation, now in the position to refund the start-up contributions provided by the MSMA and MAOPS in 1983, presented a refund check to MSMA.

MSMA, MAOPS, and the Board of Registration for the Healing Arts discussed communications, statute of limitations, and competency hearings. MSMA supports the position that only physician members of the State Board should conduct competency hearings for physicians.

The MSMA Resident Section requested and the Council approved a free one-year trial membership for residents.

A recommendation from the Forrest T. Jones Company to change the underwriters for the MSMA Term Life Policy to Northwestern National Life Insurance Company was approved. The Council also approved MSMA's participation in the AMA Coalition for Quality End-of-Life.

Gordon Johnson, MD, Festus, was reappointed to the AMA Advisory Committee on Minority Physicians. Turner Minnigerode, MD, Kansas City, and Walter Davisson, MD, Jefferson City, were recommended for reappointment to the Board of the Missouri Patient Care Review Foundation. Drs. Deborah Jantsch, Larry Rues, Kansas City, and Robert Schaaf, St. Joseph, were appointed to serve on the 1997 Committee on Arrangements for the Annual Convention to be held at the Westin Crown Center, April 10-13.

Meeting of November 17, 1996, Jefferson City

The MSMA Council directed the Committee on Legislative Affairs to develop legislation prohibiting substitution of B-rated generic drugs in Missouri by either in-state pharmacies or out-of-state mail order companies in accordance with AMA policies. The Committee will also study the possibility of legislation to prohibit out-of-state therapeutic substitutions of prescriptions in accordance with current policy. Part of this effort includes educating its membership to specify

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A-rated generics when authorizing generic drug substitutions on the state-approved prescription form. MSMA also announced its position on generic substitution, i.e. when a physician allows for generic substitution, only FDA A-rated generic drugs should be substituted.

The Committee on Legislative Affairs was directed by Council to support the Board of Healing Arts in its efforts to make several changes in Missouri's licensing statutes; to continue to pursue the statute of limitations legislation; to seek passage of legislation to require HMO medical directors to be licensed to practice medicine in Missouri; to have its breast reconstruction insurance coverage bill reintroduced in 1997; and to support the dermatologists in their efforts for direct access and will consider supporting other specialties with similar legislation. The Council approved MSMA's 1997 operating budget of $1,682,970. The Council also approved MSMA filing an official complaint with the Missouri Department of Insurance and/or the Attorney General's office regarding the nonpayment of valid claims by United HealthCare.

The MSMA Executive Committee will study the development of a policy statement on mergers of hospitals (or other treatment facilities) and insurance companies as not being in the best interest of patients. If appropriate, the Executive Committee is to present this statement to the Attorney General's office and the Eighth Circuit Court. A resolution on this subject is to be developed for presentation at the 1997 Annual Convention.

The MSMA Council endorsed a mission statement proposed by MAOPS and the Missouri Association of Local Public Health Agencies on formalizing the role of physicians in public health departments and will reconsider the proposed job description for a medical director of local public health agencies when a final version is available.

MSMA will develop a statewide mini-internship program (in conjunction with the component medical societies) whereby local news media, attorneys, businessmen, and lawmakers would shadow a practicing physician. MSMA's Key Contact Network will be utilized for this program.

The Council directed MSMA President, Daniel O'Sullivan, MD, to appoint an ad hoc committee to make a single recommendation on the issue of AMA Delegation apportionment to be presented at the pre-convention Council Meeting in April. The Council also tabled the issue of current MSMA policy on funding for AMA candidates until the January Council meeting.

The MSMA Young Physicians Section was directed to study the credentialing problems encountered by new physicians trying to contract with an HMO.

MSMA's Executive Committee will study the Medical Student Section's request to utilize the Association's Health Education Foundation as a depository for tax-free donations to help sponsor their preceptorship program that will begin in the summer of 1997. The Executive Committee will also research a proposal by the MSS to develop a membership lapel pin for students and physicians.

The Association's Membership Division will inquire of physicians why some do not renew their MSMA membership in order to gain insight on membership benefits.

The Council approved proxy for Drs. Daniel O'Sullivan, A.J. Campbell, Stephen Vilmer, William Dorzab, and Mr. C. C. Swarens to vote MSMA stock in MOMEDICO at its Annual Meeting in January. The appointment of J. Michael Zylka, MD, to fill the unexpired term of Randall Treadwell, MD, as 3rd District Vice Councilor was endorsed. MSMA also voted to support the candidacy of Jo-Ellyn Ryall, MD, for the AMA Council on Constitution and Bylaws.

The Council approved the following reports and their recommendations: President, Executive Vice President, Physicians' Health Committee, Commission on Medical Education and Health Manpower, MoMed Net, Commission on Public Affairs, Cancer Control Project, Commission on Interspecialty Medicine, and the Report on the conference of family violence including the recommendation that MSMA publish on a regular basis family violence issues.

Meeting of January 26, 1997, Jefferson City

Concern over the possible merger of BJC Health System and Blue Cross and Blue Shield of Missouri was expressed at the MSMA Council Meeting, Sunday, Jan. 26, 1997, in Jefferson City. The Council stated that merging BJC, the largest health system in Missouri, and Blue Cross and Blue Shield of Missouri, which covers approximately one in three Missourians, could lead to decreased competition in Missouri's health care market. MSMA sent a press release explaining its concern to 45 statewide media outlets. After completion of a study by the AMA regarding similar mergers nationwide, MSMA plans to develop a policy statement regarding such mergers.

Another issue the Council discussed was one of media coverage of professional liability actions while the cases are still in litigation. The Council approved a recommendation to refer this issue to the Conjoint Medical-Legal Committee and to work with the Missouri Bar Association to formulate a policy discouraging coverage.

The 1996-97 Legislative Awards will be presented to Senator Sam Graves, Tarkio; Senator Joe Maxwell, Mexico; Rep. Tim Harlan, Columbia; and Rep. Charles Shields, St. Joseph. The 1996-97 Citizenship and Community Service Award will be presented to James Blaine, MD, Springfield; William H. Gondring, MD, St. Joseph; and James A. Kinder, MD, Cape Girardeau.

A special presentation during the Annual Convention will be made to Jack Croughan, MD, and Mr. Bob Bondurant, both of the Missouri Physicians' Health Program, in recognition of their excellent work and support of impaired physicians.

MSMA endorsed Jo-Ellyn M. Ryall, MD, for a seat on the AMA Council on Constitution and Bylaws. Financial support will be provided up to the current limit of $5,000. The Council also approved presenting a resolution from the Council to the 1997 House of Delegates that would amend current MSMA policy for funding campaigns for AMA Councils and Board of Trustees, increasing the limit for Board of Trustees from the current limit of $10,000 to $20,000 and the limit on AMA Council seats from $5,000 to $10,000. If passed at the 1997 Annual Convention, the new limits will apply to any candidates running for AMA offices.

The Missouri Physicians' Health Program (MPH), reported the November 1996 *Southern Medical Journal* published an article about the results of a study which revealed a 94% recovery rate of those physicians enrolled in MPH. The program also announced that there are five De Novo spouse support programs available throughout Missouri.

The Commission on Medical Economics, Third Party Medicine, and Governmental Relations reported that MSMA will be participating with MAOPS and the Missouri Association of Local Public Health Agencies in a meeting to discuss public health and primary care issues. MSMA also has issued a request for proposals and received 12 bids to operate a credential verification organization.

MSMA also may contract with the AMA's new American Medical Accreditation Program, a program designed to create physician certification standards relating to quality much like the NCQA.

The Council approved pursuing the merger of Missouri State Medical Services and Missouri State Medical Insurance (MSMI), two wholly-owned subsidiaries of MSMA. MSMI, formed in 1974, sponsors tours for MSMA members and was one of the original stock holders in MOMEDICO, the Association-sponsored professional liability company. MSMS, formed in 1993 with a loan from MSMA, has been studying and attempting to develop an Association-sponsored managed care organization.

MSMA's membership division will extend the one-year free trial membership to resident physicians who are spending their first year in Missouri, even though they may not be first year residents. An earlier solicitation resulted in 43 new resident members from this one-year free membership program.

The Council made the following nominations or appointments: re-nominated H. Jerry Murrell, MD, Columbia, to the AMA Council on Legislation when a slot on the Council becomes available; nominated Gordon Jones, Jr., MD, Sikeston, and Frank Mohs, MD, St. Louis, for re-appointment to the Board of Directors of the Missouri Patient Care Review Foundation; and nominated Sangeeta Jain-Roberts, MD, Jefferson City, to serve on the Drug Use Review Board of the State Division of Medical Services.

The Council approved reports from the President, Executive Committee, Executive Vice President, Committee on Continuing Education, MSMA Alliance, Legislative Affairs, Missouri State Medical Services, Inc., Councilors, Membership, and AMA.

Commission on Medical Economics, Third Party Medicine, and Governmental Relations

The following resolutions were sent to this Commission by MSMA Council resulting from action by the MSMA 1996 House of Delegates.

Resolution #3: Statewide Credential Verification Service.

Adopted by the MSMA House of Delegates.

RESOLVED, that the MSMA, in conjunction with component medical societies, offer a member benefit of a credential verification service that meets all of the standards established by the JCAHO and the NCQA.

STATUS: MSMA received eleven proposals from existing credential verification organizations (CVO) in response to a request for proposal by MSMA seeking a CVO which would provide credentialing services for MSMA members. These proposals are still being reviewed at the time this report was written.

Resolution #4: Plastic ID Cards for Managed Care Patients.

Adopted by the MSMA House of Delegates.

RESOLVED, that the MSMA develop with health care insurers a uniform electronic system of verifying patient eligibility with the costs being borne by insurers.

STATUS: Research has indicated that this should be feasible in 1997 or 1998.

Resolution #5: Statewide Managed Care Organization.

Adopted by the MSMA House of Delegates.

RESOLVED, that the Missouri State Medical Association, in cooperation with Missouri State Medical Services, Inc., Renaissance HealthCare Partners, Inc., and other sources, develop a report on the feasibility of organizing a physician-owned and operated managed care organization and that this report be provided to the MSMA membership after being presented at the August 1996 MSMA Council meeting.

STATUS: A committee of 21 physicians and managed care professionals produced a report which was published in the June 1996, *Missouri Medicine.*

While the resolution called for a feasibility study of

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organizing a physician-owned and operated managed care organization, the committee recommended to the MSMA Council what it believes to be a more primary ingredient to address the needs of Missouri physicians - the development of a management services organization (MSO). By providing access to top management talent through the proposed MSO, physicians will be better organized to compete for managed care contracts.

The MSMA Council approved the committee's two recommendations.

1) That the MSMA Council endorses the concept of a statewide management services organization (MSO) as proposed by this Committee and MSMS.
2) That the MSMA Council authorizes the Board of Directors of MSMS, in consultation with the MSMA Executive Committee, to proceed with the formation of an MSO as proposed by the Saint Louis Management Group.

At the time of this writing, negotiations are underway for a joint venture partner to operate the MSO for MSMS.

Commission on Medical Economics, Third Party Medicine, and Governmental Relations: Phil Hornbostel, M.D., Chair; Emil Miscovsky, M.D.; Don Cole, M.D.; Steve Buie, M.D.; Richard Gutknecht, M.D.; Carl Strauss, M.D.; Michael Bukstein, M.D.; Milamari Cunningham, M.D.; William Stricker, M.D.; Ron Riner, M.D.; Tim McIntire, M.D.; George Hubbell, M.D.; Ann Peick, M.D.; James Rogers, M.D.; Narendra Shah, M.D.

Committee on Constitution and Bylaws

The Missouri State Medical Association's Committee on Constitution & Bylaws recommends the following changes to the MSMA Constitution be adopted. These changes were presented in during the 1996 MSMA Annual Convention and, in accordance with the Bylaws, were published for the membership in the January and February 1997 issues of *Missouri Medicine*.

Article ~~IV~~ III. House of Delegates

Article ~~V~~ IV. Council.

The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, the duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, Resident Physician Section, and the ~~Hospital~~ Organized Medical Staff Section. A majority of the voting members of the Council shall constitute a quorum.

Article ~~VI~~ V. Council on Ethical and Judicial Affairs

Article ~~VII~~ VI. Sessions & Meetings

Article ~~VIII~~ VII. Officers. Section 2.

The officers shall be elected annually. The term of Councilors and Vice-Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor, and ~~hospital~~ organized medical staff Councilor, who shall each be elected to a one-year term.

The delegates from the Medical Students Section, the Resident Physicians Section, and the Hospital Organized Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor.

Article ~~IX~~ VIII. Funds, Expenses and Budget

Article ~~X~~ IX. Referendum

Article ~~XI~~ X. Seal

Article ~~XII~~ XI. Amendments.

The House of Delegates may amend any article of the constitution by a two-thirds vote of the delegates present and voting in any Annual Convention, provided that such amendment shall have been ~~presented in the previous open meeting of the House of Delegates and that the amendment shall have been~~ published twice during that year in the Journal of the Association or sent officially to each component society at least two months prior to the meeting at which the final actions are to be taken.

Committee on Constitution and Bylaws: Donald Potts, M.D., *Kansas City*; Sheila Shah, M.D., *St. Joseph*; Jean Chapman, M.D., *Cape Girardeau*; Arteso Raborar, M.D., *Springfield*; Lawrence Lampton, M.D., *Columbia*

Committee on Continuing Medical Education

The Committee on Continuing Medical Education met on January 18, July 31, August 24, and November 11, 1996.

The MSMA Mission Statement for Continuing Medical Education was reviewed and approved deleting the following paragraph:

> The Missouri State Medical Association regularly publicizes ongoing Category 1 programs in its monthly publication, *Missouri Medicine*. Accredited sponsors and organizations are encouraged to use this publication as a means of publicizing their programs.

This statement will be incorporated into the Continuing Medical Education Policies and Procedures. MSMA will continue to publish Category 1 CME offerings in *Missouri Medicine*.

A draft of a Policy on Mergers of Accredited Sponsors was reviewed. The Committee members recommended this draft be revised to conform to the Continuing Medical Education Policies and Procedures.

The Committee members are studying the feasibility of offering continuing medical education on the Internet. A physicians advisory committee is being formed to provide input and guidance into the development of the MSMA Internet Program.

In order to formalize the process of jointly sponsoring educational activities with non-accredited entities, the Committee members reviewed a form for joint-sponsorship. It was the consensus of the members that such a form would ensure that this Committee is integrally involved in the planning and implementation of educational offerings that are jointly sponsored. In addition, this form would also ensure that the Essentials are adequately met.

On August 24, 1996, the Committee for Review and Recognition (CRR) of the Accreditation Council for Continuing Medical Education met with members of the MSMA Committee on Continuing Medical Education to consider re-recognition of the Missouri State Medical Association as an accreditor of intrastate providers of continuing medical education. On September 5, 1996, the CRR approved four years of recognition for the Association.

Committee members reviewed Section 537.035, RSMo, *Peer review Committee-composition, purpose—immunity from civil liability, who, when—disclosure of records prohibited, exceptions—testimony before, discovery and admissibility, limitations.* It was the consensus of the members that accessing peer review records by "a health care licensing board of the state of Missouri" would have a detrimental impact on physicians' participation in future peer review activities.

The Committee members approved the following requests for Joint-Sponsorship:

- St. Louis STD/HIV Prevention Training, February 5, 1996
- Missouri Rural Health Association's Second Annual Conference, April 2-3, 1996
- Cytopathologists Conference, May 11, 1996
- Sixth Annual Medical-Legal Symposium, September 7, 1996
- Fifth Annual Rural Elderly Conference, September 26-27, 1996

The Committee members recommended the following organizations be recognized as sponsors for CME activities based upon their compliance with the Essentials and Guidelines for Continuing Medical Education:

- Audrain Medical Center, Mexico
- Baptist Medical Center, Kansas City
- Bothwell Regional Medical Center, Sedalia
- Buchanan County Medical Society, St. Joseph
- Deaconess Medical Center, St. Louis
- DePaul Health Center, St. Louis
- Doctors Regional Medical Center, Poplar Bluff
- Fulton State Hospital, Fulton
- Hannibal Regional Hospital, Hannibal
- Independence Regional Health Center, Independence
- Kansas City AIDS Research Consortium, Kansas City
- Kansas City Society of Ophthalmology and Otolaryngology, Kansas City
- North Kansas City Hospital, North Kansas City
- Parkland Health Center, Farmington
- St. Anthony's Medical Center, St. Louis
- St. Joseph Hospital, Kirkwood
- St. Mary's Health Center, St. Louis
- Western Missouri Mental Health Center, Kansas City
- St. Mary's Health Center, Jefferson City

We appreciate the participation of the following Committee members: Michael Vannier, M.D., Chair, *St. Louis*; J. Thomas Critchlow, M.D., *Cape Girardeau*; Gerald Duling, M.D., *St. Charles*; William Gondring, M.D., *St. Joseph*; Richard Heimburger, M.D., *Osage Beach*;William Larsen, M.D., *Shawnee Mission, KS*; David Martin, M.D., *Chesterfield*; Mark McClung, M.D., *Kansas City*; George Trimble, M.D., *Kansas City*

Commission on Continuing Education and Health Manpower

The Commission on Continuing Education and Health Manpower met on July 31, 1996.

The MSMA Council referred the following two resolutions to the Commission for consideration:

Substitute Resolution #1 and #2

RESOLVED, MSMA staff work with the Missouri Board of Pharmacy and the Missouri Pharmacy Association to develop guidelines to minimize duplicative and/or contradictory patient education, and to develop a mechanism to ensure that patients report drug side effects to the physician prior to drug cessation.

The Commission members expressed their willingness to assist in the development of such guidelines and will provide a progress report to the next Council meeting.

Substitute Resolution #12

RESOLVED, that MSMA complete its efforts in establishing a statewide information network.

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Members discussed the program, MoMed Net, created by MSMA and Sprint Healthcare Systems that provides MSMA members with full unlimited Internet access. This service was available to members in St. Louis, Kansas City, Springfield, and Jefferson City on July 15, 1996.

The Commission members reviewed the plans for the 1997 MSMA Annual Convention that will be held on April 10-13, 1997, at the Westin Crown Center in Kansas City, Missouri.

Commission members reviewed and approved the MSMA Mission Statement for Continuing Medical Education without modification.

We appreciate the participation of the following Committee members: Michael Vannier, M.D., Chair, *St. Louis*; J. David Auner, M.D., *Ironton*; David Fleming, M.D., *Moberly*; J. Thomas Critchlow, M.D., *Cape Girardeau*; David Martin, M.D., *Chesterfield*; George Trimble, M.D., *Kansas City*; Mark McClung, M.D., *Kansas City*; William Larsen, M.D., *Shawnee Mission, KS*; Gerald Duling, M.D., *St. Charles*; David Glover, M.D., *Warrensburg*; William Gondring, M.D., *St. Joseph*; Richard Heimburger, M.D., *Osage Beach*; John Kelly, M.D., *Joplin*

Missouri State Medical Foundation

Since its inception in 1960, the Foundation has loaned more than five million dollars to Missouri medical students, with more than two million being loaned in this decade.

In its thirty-seventh year of operation, the Foundation enjoys a very strong financial statement having again received an unqualified opinion from the auditor for 1996 financial statements.

The current financial strength of the Foundation is due to the strong support received from the MSMA and the MSMA Alliance. MSMA members were assessed $10 a year until 1987 and the Alliance has targeted the Foundation for contributions through Christmas fund-raising efforts. At the request of the Foundation, future Alliance fund-raising efforts will be directed toward the new MSMA Health Education Foundation.

The financial statements of MSMF appeared in the March 1997 issue of *Missouri Medicine.*

MSMF Board of Trustees: Miles C. Whitener, M.D., President; Frederick W. Hahn, M.D., Vice President; Robert H. Tanner, M.D., Secretary-Treasurer; Patrick B. Harr, M.D.; Harold Lurie, M.D.; Robert Schaaf, M.D.; James E. Allan, M.D.; Christopher H. Jung, M.D.; Donald Fakhoury, M.D.

Report of the Physicians Health Committee

The Missouri Physicians Health Committee met on May 18 and September 21, 1996.

The De Novo Program was started in 1995 for the spouses of physicians enrolled in the Missouri Physicians Health Program (MPHP). The Program is also open to the spouses of Missouri physicians who are not in the MPHP. Currently, there are De Novo groups in St. Louis, Cape Girardeau, Poplar Bluff, and Springfield. It is anticipated that similar groups will soon be functional in Kansas City, Columbia, and Jefferson City. What was a voluntary effort in 1995, the current budget provides funds for the facilitators to conduct one support group meeting per month in the four locations.

The MPHP staff has presented a program regarding the aspects of the De Novo Program to the Alliance and additional programs will be scheduled in the future. The Alliance has expressed an interest to become more involved in medical family issues and will schedule a medical family enrichment program within the next few months.

Committee members were encouraged to contact their local hospitals to determine a willingness to contribute to the MPHP. The MPHP staff will be contacting the MSMA Councilors to obtain their assistance in generating contributions for the Program. A listing of Missouri hospitals with key contacts will be sent to each Councilor. This information also includes the history of hospital contributions.

The Committee members discussed the changes that have occurred within the Missouri Board of Healing Arts since the Memorandum of Understanding was executed in December 1994. The MPHP staff presented an educational offering to the members of the Board of Healing Arts regarding the components of the MPHP.

The following goals were identified for 1997:

- To conduct the implementation phase of the De Novo Program.
- To maintain close communications with the Board of Healing Arts.
- To expand psychotherapy groups.
- To continue fund-raising efforts.
- To expand efforts in contacting regulatory agencies regarding MPHP educational programs and services.

In order to better inform the MSMA members about the services of the MPHP, the Committee members suggested incorporating Program information into the MSMA Home Page.

A motion was made, seconded and approved to adopt the 1997 proposed MPHP budget with an income of $167,500 and expenses of $190,090. The financial statements of MPHP appeared in the March 1997 issue of *Missouri Medicine.*

The members discussed establishing a Physicians Health Assistance Fund modeled after the Texas Medical Association Committee on Physicians Health and Rehabilitation. Recognizing that many participants have exhausted family and personal resources, monies from this fund would defray legal fees and expenses incurred with drug screens. Contributions to this fund primarily would be provided by the current and past participants in the MPHP.

A motion was made, seconded and approved to establish a Physicians Health Assistance Fund to accept tax-deductible contributions under the current 501(c)(3) status of the MSMA MPHP.

The Committee members approved the following additional item to the Physicians Health Program Advocacy Agreement:

> *Should I relocate to another state, I authorize the Missouri Physicians Health Program to disclose information regarding my affiliation with the Missouri Physicians Health Program to the applicable physician health program in the state to which I am relocating so that there may be a continuity of documentation concerning my recovery.*

The Committee members expressed their sincere appreciation to the institutions that generously supported the MPHP.

We appreciate the participation of the following Committee members: Thomas Anderson, M.D., Chair, *Columbia*; John Lyskowski, M.D., *Jefferson City*; Thomas Cochran, M.D., *Springfield*; Charles Sincox, M.D., *Washington*; Michael Freeman, M.D., *Cape Girardeau*; Donald McIntosh, M.D., *Lee's Summit*; K. Lynn Moritz, M.D., *St. Louis*; Hugh Bartlett, M.D., *Rolla*; Jo-Ellyn Ryall, M.D., S*t. Louis*

Commission on Interspecialty Medicine

The Commission on Interspecialty Medicine met on June 26, 1996.

Commission members were informed that the Missouri Psychiatric Association has supported legislation introduced during the 1996 Missouri General Session seeking parity for mental illness. It was noted that psychiatric illness is just as serious as any other medical illness and there should not be more restrictions placed on levels of reimbursement by insurance companies. The efficacy of psychiatric treatment is equal to that of other medical specialties.

Members of the Central Society of Physical Medicine and Rehabilitation also noted that individuals with serious physical disabilities do not receive full medical coverage.

MSMA has supported full parity and has recommended that the Joint Interim Committee on Managed Care incorporate similar language in its final report.

It was the consensus of the Commission members that managed care organizations fall short in the provision of their services.

The Commission members discussed plans for the 1997 MSMA Annual Convention that will be held on April 10-13 at the Westin Crown Center Hotel in Kansas City, Missouri. Specialty organizations currently are in the process of determining their programs that will be sponsored during the MSMA Annual Convention.

Commission members were informed about the MSMA Internet Program, MoMed Net, whereby MSMA members are provided with full, unlimited access to the Internet.

We appreciate the participation of the following Commission representatives: Mark Martin, M.D., Chair, *Family Phy.*; Mark Vandewalker, MD, *Allergy*; Don Cole, M.D., *Anesthesiology*; George Hruza, M.D., *Dermatology*; Michael Szewczyk, M.D., *Emergency Physicians*; James Rogers, M.D., *Internal Medicine*; Joseph Hanaway, M.D., *Neurology*; David Jimenez, M.D., *Neruosurgery*; John Anstey, M.D., *OB-GYN*; Matthew Lewis, M.D., *Ophthalmology*; Thomas Highland, M.D., *Orthopaedic Surgery*; Greg Renner, M.D., *Otolaryngology*; Michael Caughron, M.D., *Pathology*;Ted Groshong, M.D., *Pediatrics*; Thomas Lieb, M.D., *Physical Medicine*; William Huffaker, M.D., *Plastic Surgery*; Tom Anderson, M.D., *Psychiatry*; Roger Francis, M.D., *Radiology*; Michael Bukstein, M.D., *Surgery*; Dennis Pzyszczynski, M.D., *Thoracic*; Mirchael Chehval, M.D., *Urology*

Commission on Medical-Legal Affairs

The MSMA Commission on Medical-Legal Affairs became more active this year. We hope to continue strengthening our relationship with the Missouri Bar Association in an effort to develop initiatives that benefit both professions. The following issues were monitored by the Commission during the last year.

Interprofessional Code: In November, members of the Commission met jointly with the appropriate committees from the Missouri Bar Association and the Missouri Association of Osteopathic Physicians and Surgeons in an effort to compose a revised Interprofessional Code. The Commission has reviewed the existing Missouri Interprofessional Code and is preparing to present our suggested revisions to the joint committee in May. The code was originally established to provide guidance on matters when medical and legal professions commonly interact.

Medical-Legal Symposium: The sixth Medical-Legal Symposium was held September 7, 1996, in

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Columbia. This event is co-sponsored by the Missouri State Medical Association, Missouri Bar Association, Missouri Association of Osteopathic Physicians and Surgeons, and the Missouri Hospital Association. Approximately 100 physicians and attorneys attended the day's seminars. The symposium was developed to address liability issues, litigation preparation, and advanced directives.

Commission on Medical-Legal Affairs: Marc Taormina, MD, Chair; Edmond B. Cabbabe, MD; Darrel D. Domann, MD; Roger A. Francis, MD; Ted Groshong, MD; Joseph A. Corrado, MD; Kenneth J. Bennett, MD; Gus S. Wetzel, MD; William F. Snidle, MD; Grant A. Bever, MD; Gregory H. Branham, MD; James Criscone, Jr., MD; Ronald Morley, DO; Howard Braby, MD

MSMA Peer Review Consultants System (PRCS)

The MSMA operates the Peer Review Consultants System (PRCS) for use by hospitals or HMO's which are in need of an expert opinion from objective physicians. Many specialists, even in metropolitan areas, know each other or are in direct economic competition. As a result, MSMA has created a statewide system to match requesting organizations that have a privileging or credentialing matter with physician specialists from a different part of the state. This will allow differences to be resolved by objective physicians outside of the courtroom.

Since MSMA is in business to serve its physician members, we have created the following memorandum to be signed by any physician being reviewed to ensure he or she is aware of the MSMA involvement.

Physician Consent to MSMA Peer Review Consultation

I understand that I have a right to an impartial and objective review of my conduct, professional qualifications, and competence to carry out the quality situation in question. I agree to allow the Missouri State Medical Association to appoint one or more physician reviewers who are not in direct economic competition with me and not prejudicial for or against me or the reviewing body which is considering the quality situation giving rise to this review.

I understand that the process will meet the requirements for fairness as outlined in the Health Care Quality Improvement Act of 1986 and that the confidentiality of the procedures are protected by Missouri Peer Review Statute, Section 537.035, RSMo.

In consideration of the designation of an independent peer reviewer I hereby release, waive and discharge Missouri State Medical Association, its agents, employees, representatives, successors and assigns from any and all claims, demands, damages, actions or causes of action whatsoever, whether existing in tort, contract, equity or otherwise which I have or might have for any loss, damage or injuries sustained by me arising directly or indirectly out of the peer review consultation, whether caused by the negligence of Missouri State Medical Association, its agents, employees, representatives or otherwise.

Name ______________________________

Signature ___________________________

Date _______________________________

Commission on Public Affairs

The Commission on Public Affairs met four times during the past year and considered the following:

Breast Cancer Brochure: Approximately 1,700 "A Woman's Choice-Alternatives in Breast Cancer Treatments" brochures have been distributed to physicians and medical offices throughout the state. The availability of the brochure was published in *Progress Notes* in August, September, October, November, December, and January. A letter and a brochure have been sent to all component societies, the Missouri Patient Care Review Foundation, the Missouri Breast Cancer and Cervical Control Project, and the Department of Health. Distribution and ordering information is available through MSMA's Home Page on the Internet. Brochures will be made available at the 1997 Annual Convention in Kansas City.

HIV Brochure/Consent Form: Approximately 2,500 "For My Patients, Taking the HIV/AIDS Test" brochures and consent forms have been distributed to physicians and medical offices. The availability of the brochure was published in *Progress Notes* in August, September, October, November, December, and January. A letter and a brochure have been sent to all component societies. Distribution and ordering information is made available through MSMA's Home Page on the Internet. Brochures will be made available at the 1997 Annual Convention in Kansas City.

Resolution #11 - Inappropriate Antibiotic Use: The Commission suggested the title of this activity be changed to reflect a positive education viewpoint, "Appropriate Antibiotic Use."

RESOLVED, that the Missouri State Medical Association join in the effort to educate physicians and the general public in the proper use of antibiotics by:

a) sponsoring lectures throughout the state to component medical societies;
b) public service announcements through television and radio;

c) providing patient information material for distribution in physicians' offices.

The Missouri Department of Health is in the process of publishing a brochure entitled, "What You Should Know About Taking Antibiotics Correctly." The Department of Health has 25 copies available for each organization requesting it. A camera-ready copy of the brochure is also available and can be printed by the organization requesting it with a space to mention "Distributed by MSMA." Approximate cost for each brochure is 15 cents. MSMA is investigating the possibility of purchasing and printing the brochure and making it available at cost to its members.

Resolution #9 -Aid to the Republic of Georgia:

RESOLVED, that the Missouri State Medical Association express its support for the efforts of the Boone County Medical Society to provide help to the independent Georgian Medical Association and aid in the improvement of health care in the Republic of Georgia.

An article was published in the September *Progress Notes* requesting relief for the Republic of Georgia. The article outlined what to donate, how to donate and contact phone numbers. A news release and updates of activity are scheduled this Spring.

Mini-Internship Coordination: This was a directive from November Council meeting whereby the MSMA would coordinate a statewide mini-internship program between component medical societies around the state. It was noted that the medical societies of Kansas City, St. Louis, Boone County, and Jasper-Newton counties have a mini-internship program in place. MSMA contacted the AMA for its newly updated mini-internship materials to distribute to the component societies and to investigate the logistics of the program.

Membership Pins as Membership Benefit: This was a directive from November Council meeting whereby the MSMA would utilize the expertise of the Public Affairs Commission to decide shape, color, size, and cost of a membership lapel pin for all dues-paying members. Current plans for pin are pending.

Formation of Statewide Speakers Bureau: A directive from the President's Meeting in June suggested developing a Speaker's Bureau and conducting media, speaker and writing training seminars; identifying issues with local and state impact and drafting position statements to use for letters to the editor or media interviews; contacting media representatives to focus issues; and keeping this list updated as issues develop.

MSMA is currently utilizing the AMA Delegation, the members of the Public Affairs Committee, and other prominent members of the membership as "media spokespersons." It was also suggested to request each medical specialty to choose a representative to participate in the Speaker's Bureau.

Faster Distribution of News and Public Service Announcements: Missouri Net and The Link are two ways to rapidly move MSMA's news through information media. Missouri Net reaches 90% of the radio markets in Missouri with its news twice an hour. The Link is an electronic wire service sending news releases to radio, television, and newspapers via modem. Costs and set-up procedures are being investigated. MSMA is also looking into creating a broadcast fax network to selected statewide media and/or utilizing the Link wire service to reach more radio/tv/newspapers.

The Public Affairs Committee intends to continue to work on improving the communications between physicians and patients in the coming year.

Commission on Public Affairs: Ann Peick, MD, Chair, *Poplar Bluff*; Jennifer Ashby, MD, *N. Kansas City*; Nancy Bunge, MD, *Mexico*; Ronnie Brownsworth, MD, *Springfield*; Suzanne Miller, MD, *Grover*; Michael Szewczyk, MD, *Columbia*; Diane Brukardt, MD, *Columbia*; Steve Halpin, MD, *Hannibal*; Ravi Mehra, MD, *St. Louis*; W. Mike See, MD, *Columbia*; Shavonne Danner, MD, *Leawood, KS*; James Blaine, MD, *Springfield*; Warren Lovinger, Jr., MD, *Nevada*; K. Lynn Moritz, MD, *St. Louis*; Kelvin Walls, MD, *Independence*

Report of the Committee on Legislative Affairs

Your Committee on Legislative Affairs met five times during the past year to analyze, discuss, and take positions on the many medically-related proposals that come before the Missouri General Assembly.

Each year legislators introduce some 1,300 bills, more than 300 of which would have some impact on the practice of medicine. The MSMA, through its staff and your Committee on Legislative Affairs, considers every piece of legislation and makes recommendations to support, oppose, monitor or amend.

Following is a brief summary of some of the more important issues currently being considered by the Missouri General Assembly. If you have any questions, members of the Committee and MSMA staff are available at this meeting to discuss the issues.

1. HB 335 and SB 223 - Managed Care Reform: This is the package of reforms recommended by the Joint Interim Committee on Managed Care. Among the key provisions in these comprehensive bills: Gag clauses would be banned; enrollees and prospective enrollees would be provided with thorough disclosures regarding the plan's benefits; managed care organizations (MCO's) would have to provide a standardized grievance mechanism for patients; MCO's would have to disclose any financial arrangements or contractual provisions that might limit or restrict the care a patient

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receives; MCO's would be required to maintain a provider network that is sufficient to assure that all services are accessible without unreasonable delay; MCO medical directors and UR physicians would have to be licensed to practice medicine in Missouri; MCO's would have to cover emergency services and could not require pre-authorization for those services; MCO's could not discriminate against the mentally ill; and de-selected providers would be given an opportunity to appeal their termination. *MSMA Position:* **Support.**

2. HB 129 - Breast Reconstruction: This would require insurers that cover mastectomy to also cover prosthetic devices or reconstructive surgery necessary to achieve symmetry following a mastectomy. *MSMA Position:* **Support.**

3. HB 100 and SB 121 - Passenger Safety: These bills would require all children ages 4-15 to wear a safety belt in a moving vehicle and require the use of seatbelts in pickup trucks. Under these bills law enforcement officials could stop a vehicle for failure to obey seatbelt laws (currently a vehicle must be stopped for some other violation before a citation can be issued for a seatbelt violation). And these bills would prohibit anyone under the age of 18 from riding in the bed of a pickup truck (certain exceptions apply). *MSMA Position:* **Support.**

4. HB 504 and SB 180 - Statute of Limitations: MSMA is supporting an attempt to prohibit the Board of Healing Arts from commencing a disciplinary proceeding against a physician unless formal charges are filed within five years of the alleged violation. As a safeguard for the public, the period of limitation does not run if the accused flees Missouri to escape the formal proceedings, engages in active concealment of the alleged violation, or during the time in which the complainant is less than 18 years of age. *MSMA Position:* **Support.**

5. HB 233 - Genetic Testing: This bill would prohibit insurers, when offering or renewing health benefit plans, from requiring, asking about the results of, or considering the results of a genetic screening test. *MSMA Position:* **Support.**

6. HB 558 - Chiropractors: This bill would grant prescriptive authority to chiropractors and delete the language in their practice act that specifically prohibits them from performing surgery, obstetrics, and other medical practices. *MSMA Position:* **Oppose.**

7. HB 102 - Lay Midwifery: This would legalize the practice of lay midwifery. Under this bill a "lay midwife" would be called a "certified professional midwife." A newly created "Council on Midwifery Registration" would be empowered to establish any education and experience requirements it deems necessary for certification. The bill has no other specific training prerequisites. *MSMA Position:* **Oppose.**

8. HB 390 and SB 144 - Emergency Services Coverage: These bills would, among other things, create a statutory definition of emergency services for insurance purposes, prohibit preauthorization for emergency services, require insurers to be available 24 hours a day to make authorization determinations, and require insurers to pay for federally-mandated emergency room screening exams. *MSMA Position:* **Support.**

9. HB 811 - KidCare: This bill would set up a non-profit corporation to provide insurance coverage for children of the working poor. This corporation would contract with insurers to provide benefits. Premiums would be based on the family's ability to pay and would be subsidized by public and private donations. *MSMA Position:* **Monitor.**

10. HB 32 - Essential Community Providers: This would require insurers to offer provider contracts to all "essential community providers" (ECP). The ECP is defined as any physician who serves in a federally-designated health professional shortage area, or serves one or more federally-designated "medically underserved populations." That physician must spend at least 20 hours per week serving this population, must be available to patients evenings and weekends, and may not be a direct employee of a health care insurer. The Department of Health would be charged with designating ECP's. **MSMA Position: Monitor.**

11. SB 129 - DWI: This would make it illegal to drive with a blood alcohol content of .08% or greater (current law is .10%). *MSMA Position:* **Support.**

12. SB 422 - Psychologists Prescriptive Authority: This bill would allow psychologists to prescribe drugs (including controlled substances) after completing 100 hours (not credit hours) of supervised clinical training and 200 hours of "independent course study" (video tapes) regarding the prescription of drugs to treat emotional and mental diseases. *MSMA Position:* **Oppose.**

13. HB 225 - Alternative Medicine: As introduced, this bill would prohibit the Board of Healing Arts from disciplining any physician for treating patients with substances or therapies which are not considered standard practice unless those substances or therapies are first found to be harmful. In other words, a physician could do just about anything until it is proven dangerous. *MSMA Position:* **Oppose.**

14. HB 539 and SB 268 - Off-Label Drug Use: These bills would prohibit insurers from refusing to pay for any drug prescribed for a covered indication on the grounds that the drug does not have FDA approval for that specific indication. The "off-label" drugs covered under this bill must have FDA approval for at least one indication, must be recognized in peer-reviewed medical literature, and must not be contra-indicated by the FDA. *MSMA Position:* **Support.**

15. SB 227 - Generic Substitution: This bill would allow a pharmacist to make a generic substitution unless the prescriber writes, in his or her own hand, the words "Brand Medication Necessary" across the face of the prescription form. ***MSMA Position:*** **Oppose.**

16. SB 76 - Gag Clauses: This bill would prohibit insurers from restricting any provider from disclosing to a patient any information regarding the nature of treatment, risks or alternatives to treatment, the availability of other therapy, the decision of any plan to authorize or deny services, or the process the plan uses to authorize or deny health care services. ***MSMA Position:*** **Support.**

17. HB 53 - Direct Access for Skin Care: This bill would allow a patient to bypass a primary care gatekeeper and consult directly with a dermatologist for skin care services. ***MSMA Position:*** **Support.**

18. HB 351 and SB 214 - Direct Access for Eye Care: These bills would allow a patient to bypass a primary care gatekeeper and consult directly with an ophthalmologist or optometrist for eye care services. ***MSMA Position:*** **Monitor.**

19. HB 167 - Board of Healing Arts: This bill would allow the Board of Healing Arts to recognize the Canadian licensing exam as a condition of licensure in Missouri and would allow the Board to grant temporary licenses to teach in any accredited hospital (current law limits these licenses to training institutions). ***MSMA Position:*** **Support.**

20. HB 168 - Physician Licenses: This would allow the Board of Healing Arts to place certain conditions on new or renewed physician's license (e.g. making licensure contingent on the applicant's continued participation in a substance abuse program). The Courts have declared the Board does not have proper statutory authority to impose conditions. ***MSMA Position:*** **Support.**

21. HB 748 - Kennedy-Kassebaum Compliance: Several bills have been introduced to bring Missouri into compliance with the Kennedy-Kassebaum health care bill passed last summer by the U.S. Congress. Under that law the states have several options to address group and individual coverage. If Missouri fails to implement its own plan, federal rules take effect.

Among other things, the Kennedy-Kassebaum bill requires health insurance policies to be portable - allowing individuals to take coverage from job to job. The law also prohibits insurers from imposing pre-existing condition limitations on their policies. As introduced, HB 748 would make these policies affordable by requiring insurers to set premiums based on a community rate. Without community rating, MSMA thinks most of the Kennedy-Kassebaum mandates would be meaningless. None of the other compliance bills offers community rating. ***MSMA Position:*** **Support.**

Commissionon Legislative Affairs: Robert N. Miller, MD, Chairman; David O. Barbe, MD; Charles Norland, MD; A.J. Campbell, MD; Daniel F. O'Sullivan, MD; William Dorzab, MD; Charles Porter, MD; Frederick Hahn, MD; Robert O. Schaaf, MD; Joan M. H'Doubler; William C. Shell, MD; Deborah A. Jantsch, MD; Robert Wankum, MD; Jerry Kennett,MD; David Wilkinson, MD; Norman P. Knowlton, III, MD; Carol F. Williams, MD; Mrs. Becky Moore

Committee on Publications

A readership survey of *Missouri Medicine* was sent to 1,400 MSMA members. We received 222 responses (16%). The purpose of the survey was to measure the benefit of the journal to MSMA members.

The majority of respondents (69%) reported that the journal has value to them. The most common statement made on behalf of the journal was the appreciation for having a publication that belonged to and focused on Missouri physicians.

Most common departments read were scientific and clinical in nature. Some members requested more general and Missouri-oriented information. A new area of content implemented in 1996-97 is Health Care Finance, Practice Management, and Quality Improvement.

Other regular items in *Missouri Medicine* include membership benefits and applications, announcements on MoMed Net, MSMA's Internet Service, and regular updates on MSMA activities.

Financially, *Missouri Medicine* is improving. Advertising income is up and expenses down. Advertising from the St. Louis area has been increasing due to an active advertising sales representative and continual improvement of journal content.

Michelle Poire was announced as the new Managing Editor for *Missouri Medicine* in February 1997.

Committee on Publications: J. Regan Thomas, MD, Chair, *St. Louis*; Phillip C. Anderson, MD, *Columbia*; John S. Daniels, MD, *St. Louis*; John C. Hagan, III, MD, *N. Kansas City*; Donald G. Sessions, MD, *Kirkwood*

Missouri State Medical Services

MSMS has consistently advocated that physicians control clinical decisions. As a wholly owned, for profit, subsidiary of the Missouri State Medical Association, MSMS is launching a management services organization (MSO) to assist physicians in managing managed care.

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This MSO is a result of MSMA resolution #5 passed by the 1996 MSMA House of Delegates directing MSMA to pursue a feasibility study of organizing a physician owned and operated managed care organization. The committee that studied this recommended to the MSMA Council what it believes to be a more primary ingredient to address the needs of Missouri physicians - the development of a management services organization. By providing access to top management talent through the proposed MSO, physicians will be better organized to compete for managed care contracts.

In addition to the MSO, MSMS will continue to act as an advocate for physicians; to assist in creating physician organizations; and promoting group, IPA, or physician organizations contracting with managed care organizations. It is only through such organizations that physicians can assume sufficient contracting risk which will allow them to also assume total clinical autonomy.

The financial statements of MSMS appeared in the March 1997 issue of *Missouri Medicine.*

Missouri State Medical Services Board of Directors: Dan O'Sullivan, M.D., President; Pat Mills, CPA, Secretary-Treasurer; Lent Johnson, M.D.; John Rollo, M.D.; Jeff Copeland, M.D.; Bill Shell, M.D.; Jerry Kennett, M.D.; Tim McIntire, M.D.; Steve Buie, M.D.; Bill Dorzab, M.D.; Fred Hahn, M.D.

MSMA Health Education Foundation

The Foundation began 1996 by continuing its operation of the MSMA medical reports for local television stations. Before this project was discontinued after February 1996, MSMA produced 135 two-minute medical reports for broadcast as part of local TV news with Regan Thomas, MD, of St. Louis as the on-air physician narrator. The reports were aired throughout Missouri on KSDK - St. Louis, KRCG - Jefferson City, KOLR - Springfield, and KCTV - Kansas City.

The Foundation is currently being used as a charitable fund raising vehicle for the support of medical school preceptorships. This project is being directed by the MSMA Medical Student Section.

Donations may be submitted to MSMA Health Education Foundation; PO Box 1028; Jefferson City, MO 65102.

The financial statements of MSMA-HEF appeared in the March 1997 issue of *Missouri Medicine.*

MSMA Health Education Foundation: Daniel O'Sullivan, MD, President, *St. Louis*; A.J. Campbell, MD, President-Elect, *Sedalia*; Norman P. Knowlton, III, MD, Secretary, *Springfield;* Edmond Cabbabe, MD, Treasurer; *St. Louis* Stephen Vilmer, MD, Council Chair, *Parkville*; Mr. C. C. Swarens, Chair, *Jefferson City.* MoMed

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1997 Recipients of the 50-Year Physician Pin

William A. Abele - *Boonville*
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Marvin R. Alberg - *Kansas City*
Mary B. Ames - *Santa Cruz, CA*
Richard L. Bartley - *Springfield*
John D. Bauer - *St. Louis*
Lucia V. Beare - *St. Louis*
Marcus R. Beck - *Columbia*
Armand E. Brodeur - *St. Louis*
Thomas W. Burns - *Columbia*
Paul J. Busiek - *Springfield*
Elza F. Butler - *St. Joseph*
Richard M. Carlin - *St. Louis*
Charles J. Cherre - *Chesterfield*
George A. Colom - *Kansas City*
Arnold Dankner - *Chesterfield*
Jack M. Davis - *Kansas City*
Harold E. Donnell - *De Soto*
Ervin H. Dorsch - *Independence*
Thomas E. Draney - *Hiwasse, AR*
Todd B. Forsyth - *St. Louis*
James W. Fowler - *Leawood, KS*
Fred D. Fowler - *Kansas City*
Donald R. Germann - *Shawnee Mission, KS*
Sidney Goldring - *St. Louis*
Fred P. Handler - *Clayton*
Robert M. Hazen - *Prairie Village, KS*
Clarke L. Henry - *Shawnee Mission, KS*
John G. Kellett - *St. Louis*
Raymond R. Knowles - *St. Louis*
William M. Landau - *St. Louis*
James T. Leslie - *Jefferson City*
Edwin T. Long - *Kansas City*
R. Stacy Long - *Lake Lotawana*
Joseph F. Lutkewitte - *Ste. Genevieve*
Francis X. Meier - *Jefferson City*
Leroy J. Miller - *Columbia*
Wilson H. Miller - *Shawnee Mission, KS*
Samuel A. Montello - *Shawnee Mission, KS*
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Virginia H. Peden - *Maryland Heights*
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Felix G. Solomon - *St. Louis*
Donald J. Stallard - *St. Joseph*
Sterling B. Suddarth - *Martinsburg, WV*
Frank D. Sundstrom - *Springfield*
Robert H. Tanner - *Jefferson City*
Otto W. Theel - *Shawnee Mission, KS*
George E. Thoma - *St. Louis*
Thomas B. Ferguson - *St. Louis*
Joseph C. Ungvari - *St. Louis*
Jerome R. Williams - *St. Louis*

R. Stacy Long, MD, Lake Lotawana, accepts his 50-Year Physician pin from Dr. O'Sullivan.

Physicians Honored for Community Service

James Blaine, MD, has spent nearly two decades in the emergency rooms at both Cox Medical Center and St. John's Regional Health Center. He juggles a full-time medical practice, membership on 18 community groups and task forces, and serves on five administrative and project committees for the St. John's Health System. Dr. Blaine has been instrumental in helping pass several pieces of MSMA-sponsored legislation. To improve the chances for heart attack victims, he helped lobby state legislators to pass a law giving more paramedics access to semi-automatic external defibrillators. To cut response times during emergencies, Dr. Blaine helped push for approval of a study to determine the efficiency of Greene County's 911 medical communications. Dr. Blaine was instrumental in gaining funding for a new Child Advocacy Center. Currently, he is working to help MSMA close loopholes in the state's driving while intoxicated legislation and increase tobacco taxes. Dr. Blaine is past Chair of the Greene County Medical Society and Springfield DWI Task Forces and has served on Governor Carnahan's DWI Task Force. He is Co-Chair of the ASSIST Community Action committee and sits on the Ozarks Fighting Back Advisory Board. He is also on the Good Community Children's Values Committee and the Community Task Force Advocates for a Healthy Community.

William Gondring, MD; James Kinder, MD; and James Blaine, MD.

William H. Gondring, MD, an orthopaedic surgeon and past president of the Buchanan County Medical Society, has been extremely active in his home town, as well as the international medical community. Since the 1960s, he has provided awareness and compassion for third world medical aid and has been recognized by the former government of Vietnam, the government of El Salvador, and the ministry of defense of the Republic of Croatia. He initially served as a civilian in South Vietnam in 1965, caring for Vietnamese patients. In 1983, he was in San Miguel, El Salvador caring for patients in the central highlands. He led an orthopaedic surgical team and performed surgeries on both El Salvadorian guerrillas and Salvadorian government troops. Dr. Gondring also began a "Save the Children" drive utilizing a Missouri Air National Guard Detachment. Working with the Heartland Health System and Representative Pat Danner, Dr. Gondring developed a health care referral system for patients severely injured in the conflict in Croatia. In 1995-96, Dr. Gondring and a colleague led a mission to the high jungles of Honduras to staff medical clinics. After returning to St. Joseph, a Honduran Medical Foundation through Heartland Health System was formed to provide equipment, supplies, and training to the Honduran clinics. He has been honored by the National Arthritis Foundation, the American Red Cross, and the St. Joseph News Press. Dr. Gondring is currently president of the medical/dental staff and is on the executive board of the Heartland Health System.

James A. Kinder, MD, has been serving his community of Cape Girardeau in many capacities since 1947 when he returned from World War II as an Air Force Captain to practice internal medicine. As a young doctor, Dr. Kinder dealt with a polio epidemic that hit Southeast Missouri and Southern Illinois in 1949-51. During that time, Dr. Kinder was one of only two physicians who were Board Certified Pediatricians in the Cape area. He was placed in an advisory position with the Department of Health and became involved with children with varicella and vaccine requirements. Dr. Kinder became involved in the Boy Scouts while attending college at Southeast Missouri State University. He has served as Scoutmaster and has received the Boy Scout's Award of Merit from the Shawnee District and the Silver Beaver by the Greater St. Louis Area Council in 1994. During the 1960s-70s, Dr. Kinder served on the State Advisory Board for the Department of Health and Dental Care for Handicapped and Retarded Children. Since then, he has supported the Missouri State Crippled Children Service and has been a member of the Board of Directors for both the state and local chapters of Easter Seals since 1975. This year, Dr. Kinder moved his practice to the Cape County Health Department where he not only continues to treat his own patients, but also the indigent children of Cape County and surrounding areas. MoMed

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I. Joe Pryor
Mark Rhoads
Howard Roberts
Duane Sherrod

Ozarks
Andres Apostol
Frank Esparrago
William Hamilton
Victor Occeno

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South Central
Laureano Mayuga

District 10
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Cape Girardeau
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Harry Wall
Joe Wall
Bruce Weaver
Mary Welch
Joseph West
Charles Wheeler
Miles Whitener
Paul Williams
Roy Wilson
John Withrow
Kishan Yalavarth

In Memoriam

The following MSMA members were recognized with a moment of silence by the House of Delegates during the 139th Annual Convention:

Harold Hoelscher, *Warrenton* - died 3/30/96
Robert Votaw, *St. Louis* - died 4/14/96
Richard Twyman, *Independence* - died 4/15/96
Donald Twedell, *Chesterfield* - died 4/19/96
Mohammed Ali, *Sedalia* - died 5/5/96
Harry Cohen, *Overland Park, KS* - died 5/15/96
Clyde Witt, *Washington* - died 5/17/96
Chong-Sup Yoo, *Festus* - died 5/20/96
Amando Ylagan, *St. Louis* - died 5/22/96
Donald Callahan, *St. Louis* - died 5/23/96
Franklin Werner, *Liberty* - died 5/24/96
Alvin Lowe, *Sedalia* - died 6/8/96
Robert Rainey, *St. Louis* - died 6/8/96
Ellsworth Westrup, *Eureka* - died 6/14/96
James O'Neil, *Prairie Village, KS* - died 6/22/96
William Mayer, *Arlington, VA* - died 6/30/96
Joseph Trigg, *Key Largo, FL* - died 7/10/96
August Cabonce, *Florissant* - died 7/14/96
Richard Ferry, *St. Louis* - died 7/16/96
Antonio Manansala, *St. Louis* - died 7/17/96
Alan Edelman, *St. Louis* - died 7/20/96
John Martin, *St. Joseph* - died 7/26/96
Theodore Repp, *St. Louis* - died 7/27/96
Reese Potter, *St. Louis* - died 7/31/96
Sigmund Gundle, *Prairie Village, KS* - died 8/1/96
Louis Forman, *Shawnee Mission, KS* - died 8/2/96
Arlen Morrison, *St. Louis* - died 8/5/96
Robert Lohr, *St. Louis* - died 8/18/96
Forest Coulson, *Shreveport, LA* - died 8/23/96
Rudy Ruhling, *Punta Gorda, FL* - died 8/23/96
Edwin Casey, *St Louis* - died 8/24/96
John Lawton, *St. Louis* - died 9/6/96
David Hall, *Rogersville* - died 9/13/96
Joseph Naryka, *St. Louis* - died 9/18/96
Don Black, *Prairie Village, KS* - died 9/21/96
Robert Mueller, *St. Louis* - died 9/29/96
William Meinberg, *North Ridge, CA* - died 9/30/96
Robert Frazier, *Sikeston* - died 10/30/96
Axel Arneson, *St Louis* - 11/1/96
Barbara Spies, *Louisburg, KS* - 11/9/96
Aloysius Gerst, *St. Louis* - 11/14/96
Shael Bronson, *St. Louis* - 11/26/96
Kenneth Waddell, *Pleasant Hope* - 11/26/96
Oscar Carron, *Perryville* - 12/12/96
William Mowrey, *St Louis* - 12/24/96
James Direnna, Sr., *Gladstone* - died 12/27/96
Frank Daley, *Hamilton* - died 12/31/96
Ralph Bohnsack, *Fort Worth, TX* - died 1/2/97
Richard Maginn, *St. Joseph* - died 1/3/97
David Paff, *Springfield* - died 1/6/97
James Stephens, *Joplin* - died 1/9/97
Katherine Crawford, *Carrollton* - died 1/13/97
August Geise, *St. Louis* - died 1/14/97
Wilfred Wooldridge, *Springfield* - died 1/18/97
August Piper, *St. Louis* - died 1/19/97
Walter Gunn, *St. Louis* - died 1/22/97
Walter Moore, *St. Charles* - died 1/22/97
Harold Budke, *Kansas City* - died 1/25/97
Donald Edgren, *Cameron* - died 1/31/97
Katherine Brown, *Overland Park, KS* - died 2/3/97
William Gillespie, *Belleville, IL* - died 2/07/97
Arturo Taca, *St. Louis* - died 2/11/97
Vance Link, *Independence* - died 2/13/97
Clyde Brower, *Independence* - died 2/15/97
John Overman, *Hutchinson, KS* - died 3/15/97
John Grant, *St Louis* - died 4/3/97
Frank Valach, *St. Louis* - died 4/7/97
Pedro Suarez-Solar, *Chesterfield* - died 4/8/97

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Remembrance

Brent R. Moody, MD

Lord help me
hold this line.

Beachhead mount
and bodies clash
all for freedom's sake.

We must fight
for what is just
we will crush the Reich.

Lord help me
as I die.

A thousand years
is much too long
to live a life that is wrong.

Watch my widow
and her unborn child.

Lord help me
hold this line.

As I march from the sea
I watch the men fall around me.

I will die on the hill
when it is my time.

Lord help me
as I die, first please help me
hold this line.

Beachhead mount
and the bodies clash
all for freedom's sake.

This poem was written in honor of the veterans who fought on D-Day.

Installation of Becky Moore 1997-98 MSMA Alliance President

Due to the death of her father, Becky Moore was unable to attend the Annual Convention in April in Kansas City. Becky was installed as the 1997-98 MSMAA President and gave this speech at the MSMA Alliance Leadership Workshop on May 6, 1997, in Columbia.

I would like to take a moment for a personal reflection. Words cannot express my gratitude to all the Missouri Alliance members who responded to me at the time of my loss of my father. He was one of my favorite people and one of God's great leaders. He was so excited about me becoming President of the MSMAA and because he believed in me and encouraged me, I can carry on.

When I came to my first State Convention as County President-Elect, I remember thinking to myself, "Who in their right mind would want to be State President? This is one job I'll never have to do." I know there are some of you thinking the very same thing.

I remember being completely awed by Sandy Mitchell and Eileen Dyer as they passed the gavel. They actually seemed to be having fun. I'm still awed by these wonderful ladies, but now I know why they chose to serve as State President–it is because of YOU–the Alliance members.

You are "can-do" people. Your enthusiasm has been contagious. Nothing is more inspiring than to be with people who are actively making changes in the lives of others. You are already making a real difference in your communities.

Our common bond is that we are all in Medical Alliance because we happen to be married to physicians, and we are concerned about the medical profession. You participate because you care about your families and communities. I know that most of you are very active in other organizations in your communities. I'm very pleased that you are. I thank you and applaud you.

John Hanley, President and CEO of LifeSpring, stated, "People don't care how much you know until they know how much you care."

I want to invite you to be my partner in caring. I want to challenge you to join together to be the calm strength in this raging storm we call medicine. The changes have been painful and divisive. Change is frightening and uncertain. However, I believe that our common bond can bring us together to make change a growing experience. By growing together, we can make a real difference in our communities. Joan has just completed an outstanding year in leadership training. Let us build on that experience, and use it to strengthen our Alliances.

I recently read that the average physician spends 60 to 80 hours a week at work. It seems that the demands of medicine take much more from our spouses, therefore, much more from the medical family. Our spouses need us to be aware of the changes in order to help them cope in a positive way.

When we join together to affect change, we become partners. A partner is one that is an equal owner; one that shares with another, one that supports. We become partners because there is strength in our bond.

Caring is protecting, watching over, feeling concerned about, or being responsible for. When we give of ourselves without thoughts of receiving anything, we care.

I believe that most of us have spent our entire marriages caring for our families and homes. We have seen when we invest our time and love in our families that we enable them to handle the many changes their lives will have. So it is with medicine. If we invest our time and love protecting and educating our communities, we strengthen the family of medicine. I believe we are privileged that we have the opportunity to serve in our communities. John D. Rockefeller, Jr., stated, "I believe that every right implies a responsibility; every opportunity, an obligation; every possession, a duty."

I believe we have a responsibility, an obligation, and a duty to give back to our communities. I believe you are the most valuable asset that your spouse has. You are valuable because you care about what your

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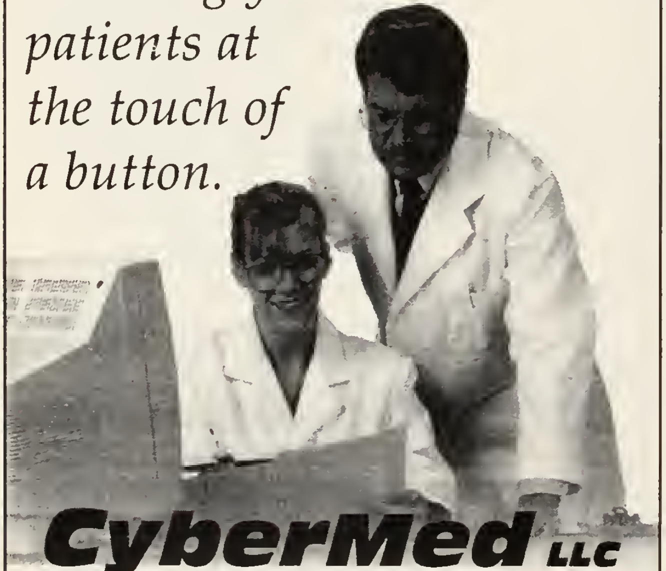
children see and hear and you care about the messages being heard in your communities. We have the opportunity to be the positive message of medicine in our communities. Our spouses need us to be positive examples. We can do so much more when we bond our resources and talents in a common cause. Shared responsibility and support builds strong families and strong communities. Your enthusiasm and attitude will be remembered because it comes from the heart. We must never underestimate the power of our lives as examples. Barbara Bush said, "Never lose sight that the most important yardstick of your success will be how you treat other people, your family, friends, co-workers, and even strangers along the way."

Our mission statement for Medical Alliance says we are "Physician Spouses Dedicated to the Health of Missouri." Let us commit ourselves to join together to strengthen our family of medicine. Let us have an attitude of gratitude as we reach out to those who are in our care. Let us make responsible decisions that keep our priorities in order. And let our enthusiasm show our genuine love and concern for others. My hope for our Medical Alliance is that we all bond together in partnership to build up our families and communities with love. Love is unique in that it multiplies as we give it away.

I would like to share one of my favorite scriptures and I am sure one very familiar to you. From the Living Bible, 1 Corinthians 13:4-8, translation: "Love is very patient and kind, never jealous or envious, never boastful or proud, never haughty or selfish or rude. Love does not demand its own way, it is not irritable or touchy. It does not hold grudges and will hardly even notice when others do it wrong. It is never glad about injustice but rejoices whenever truth wins out. If you love someone, you will be loyal no matter what the cost. You will always believe in him and always stand your ground in defending him. All the special gifts and powers from God will someday come to an end, but love goes on forever."

I believe we need to stand ground for our spouses! MoMe



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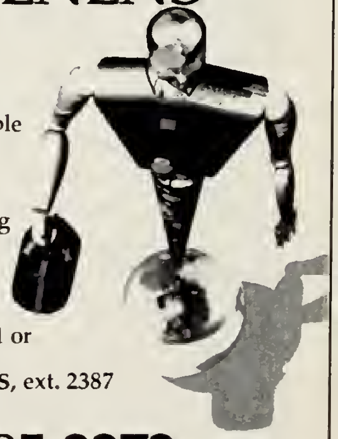

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Alliance President Joan H'Doubler's Address to the MSMA House of Delegates

In preparing this report of Alliance activities, service, and achievements of the past year, I reviewed years of reports given by Past State Presidents to the MSMA House of Delegates. I quickly recognized that while the years brought many changes, especially in regard to the most pressing of health concerns, the purpose of the Missouri State Medical Association Alliance never faltered and remains unchanged: to assist in the programs of the MSMA that improve the health and quality of life for all people, to promote health education, and to encourage participation of volunteers in activities that meet health needs. In essence: We are physicians' spouses dedicated to the health of Missouri.

While purpose and goals remain unchanged, the MSMA Alliance itself has either by evolution or resolution developed into a dynamic professional organization of men and women embracing the very serious health issues in our society today. Never has the need been greater! To meet these needs, the MSMA Alliance has developed two major programs during the past year. I would like to use this time to focus on one of these programs, and hopefully hold your attention in order to firmly implant a message in your minds.

The Alliance SAVE Program addresses violence, the most profound yet preventable health epidemic in our nation today. Initiated by the AMA Alliance to Stop America's Violence Everywhere, the SAVE Program involves efforts to end violence in America and to help victims of abuse reclaim their lives. Violence comes in many forms: sexual violence, gang and peer-related violence committed by youth of all ages, family violence, street violence, and violence in the media.

Violence is among the leading causes of death in America, and has replaced disease as the number one killer of children. Billions of dollars per year are attributed to preventable violence-related deaths and injuries, adding a tremendous burden to America's health care system. With domestic violence affecting as many as one-fourth of all American families, medical expenses from domestic violence alone total more than five billion dollars annually. As many as 35% of women seen in hospital emergency rooms are there for symptoms related to ongoing abuse, but as few as 5% of these women are identified as such.

The first step toward unraveling the many layers of our nation's violence problems can begin with awareness. Awareness and prevention are the heart of the Alliance SAVE Program.

Ryall
O'Sullivan
MISSO
STATE ME

Joan H'Doubler, MSMA Alliance President, addresses the first session of the MSMA House of Delegates.

Last fall the MSMA Alliance and its component County Alliances joined the AMA and the AMA Alliance in the national SAVE-A-Shelter Campaign. Alliances and Medical Societies were asked to unite in helping a local abuse shelter, rape crisis center, or transition home. A member of the AMA Board of Trustees, Dr. John C. Nelson, an obstetrician and gynecologist from Salt Lake City, Utah, and a spokesperson for the Alliance SAVE Program, believes that, "physicians are still very apprehensive about approaching patients they suspect are being abused." Dr. Nelson continues, "for physicians, the SAVE-A-Shelter Campaign is an opportunity to learn about the resources available for the patient who leaves the office or the hospital in need of help." AMA Alliance President Sandra Mitchell agrees. "Physicians need to know that there are local resources that provide a safety net for their patients."

That safety net is firmly in place! No strangers to helping local shelters, Alliance members rolled their sleeves a little higher. They aided victims through "shelter

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showers," ongoing fundraising projects, provision of badly needed clothing items, and even renovating and furnishing accommodations at local abuse shelters.

Thousands of "I Can Choose" conflict resolution books, originated by the AMA Alliance, designed to teach school children skills to cope with anger and conflict, were distributed throughout Missouri. "Hands Are NOT for Hitting" artwork sheets provided a tool for thousands of young children in both schools and shelters to master an important lesson: hands are for holding, playing, and sharing, hands are not for hitting.

Alliance projects involving the distribution of educational and awareness materials to Missouri physicians and health care professionals regarding domestic abuse are underway. All of these tangible accomplishments give evidence of the dedication and purpose of Alliance members in lessening the toll violence is taking in our communities.

Physicians can play a pivotal role in diagnosing and preventing domestic violence and treating its victims, and to that end, the AMA has and will play a pivotal role. The AMA believes domestic violence and its medical and psychiatric injuries are sufficiently prevalent to justify routine screening of all women patients, especially those in emergency, surgical, primary care, pediatric, prenatal and mental health settings. The AMA has developed diagnostic and treatment guidelines for the seven major areas of abuse, solicits every physician for membership in the Coalition of Physicians Against Family Violence, and urges incorporation of family violence into the curricula of medical schools (85% of schools report now having such programs). The AMA urges physicians, legislators, educators, attorneys, judges, social workers, law enforcement personnel, and the media to work together for a society that treats domestic violence as a serious public health program as well as a serious crime and to treat its victims with courage, compassion, and commitment. The AMA has responded to this public health threat with action. I am asking you, as leaders in the Missouri State Medical Association and in your counties, to hear my message and take action here in Missouri on what the AMA is committed to addressing: the awareness of domestic abuse and assistance to its victims in reclaiming their lives. Make an effort to become aware of the Medical Alliance SAVE Program activities in your community; join the AMA initiative and Alliance efforts to help cope with our nation's fastest growing homeless population . . . women and children seeking refuge from violent homes.

The De Novo Program, reported very briefly here, is the second program newly developed this year. Meeting a need within our organizations, it is a program sponsored by the MSMA for not only the spouses of physicians enrolled in the Missouri Physicians Health Program but also the spouses of Missouri physicians who are not in the MPHP. If that spouse is seeking help, they are welcome to contact the Program.

The Missouri Physicians Health Program and De Novo Program are under the direction of Dr. Jack Croughan with Robert Bondurant, RN, LCSW, as Program Coordinator. Group facilitators are available in St. Louis, Kansas City, Springfield, Cape Girardeau, and Sikeston.

Before concluding this report I wish to express appreciation to those of you recognized as an "Alliance Member Spouse." For those of you who are not, please consider giving your spouse a gift of Alliance membership. Information is available from the MSMA State Office or an Alliance member.

Also, my appreciation to those attending the AMA Education and Research Foundation fundraising dinner and art auction, "Stardust, Top Hats & All That Jazz." The Deans of our Missouri medical schools are being presented with AMA Education and Research Foundation checks totalling $56,844.68. The entire evening has been very generously underwritten by the Missouri Beef Industry Council and Columbia Independence Regional Health Center, making your donation of $75 a person 100% tax deductible. A contribution is appreciated from those unable to attend.

On behalf of the MSMA Alliance, I bring you best wishes for a very successful and productive 139th Annual Convention. MoMed

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Results of Blood Lead Screening in Children Referred for Behavioral Disorders

Thomas D. Eppright, MD; Sarah J. Vogel, MD;
Ellen Horwitz, PhD; Heather D. Tevendale
University of Missouri-Columbia, Department of Psychiatry/Neurology

Abstract

This study reviews findings from blood lead level screening in children referred to an Attention Deficit Hyperactivity Disorder clinic. Results obtained from 102 children revealed a sample mean blood lead level of 2.29µg/dL and one patient with a mildly elevated blood lead level. Comparing these findings to results of national studies suggests that these children are not at higher risk for elevated lead levels than is the average child living in a similar setting.

Introduction

Environmental exposure to lead is well recognized as a significant health problem in this country.[1] Lead exposure is of special concern in the pediatric population because children are more likely to ingest lead in the environment through hand-to-mouth activity and intestinal absorption of lead is more efficient in children than in adults.[2] In addition, the developing central nervous system of a child is much more susceptible to the deleterious effects of the ingested lead.

Though considerably higher blood lead levels were recently considered safe, research throughout the last decade has led the Centers for Disease Control (CDC) to define lead levels of 10µg/dL or less as acceptable.[3] The results of Phase 1 of the National Health And Nutrition Examination Survey (NHANES III) were recently published indicating that the average blood lead level in the United States is now down to 2.8µg/dL.[4] However, blood lead levels continue to be highest among young children.[4] Additionally, the type of community in which children reside also appears to be related to risk for lead exposure, with one recent study finding a mean lead level of 10.4µg/dL in inner city children compared to 4.3µg/dL in rural children.[5] Phase 1 of the NHANES III replicated these results.[4]

Elevated blood lead levels have been linked to both behavioral and developmental disorders. Studies have found significant relationships between lead levels in children and hyperactivity, antisocial behavior, learning disorders, and school failure.[6, 7, 8, 9, 10, 11, 12, 13] Levels as low as 10µg/dL are associated with deficits in attention span and lower IQ. As a result of these research findings, children referred for behavioral problems have frequently been screened for elevated blood lead levels.

The current body of evidence suggests that elevated lead levels may in some way be related to behavioral disorders in children. The purpose of this study is to examine blood lead levels in a population of children with behavior problems in order to consider whether or not they are at greater risk for elevated lead levels as compared to the average for children living in a similar setting.

Methods

Between January of 1992 and March of 1995, blood lead levels were drawn on 102 children referred to the Child Psychiatry/Child Health Clinic at the University Hospital and Clinics in Columbia, Missouri. These children were referred by pediatricians for the evaluation of behavior problems suggestive of Attention-Deficit Hyperactivity Disorder (ADHD). The children ranged in age from 2 to 15 with a mean age of 8 years. The group consisted of 16 (15.7%) females and 86 (84.3%) males. None of the children had a history of lead poisoning.

Venous blood samples were drawn and sent to the toxicology laboratory where they were run on an EFA Model 3010B Blood Lead Analyzer using anodic stripping voltammetry.

Results

Of the 102 children tested, only one of the subjects had a

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blood lead level above the maximum acceptable level of 10μg/dL. This subject had a blood lead level of 11μg/dL. The mean blood lead level was 2.29μg/dL with a range of 0 to 11μg/dL. To date, no single risk factor explains why this child had an elevated blood lead level. The child with a blood lead level of 11μg/dL was started on a treatment protocol as recommended by the University of Missouri-Columbia Department of Child Health.

Discussion

The findings indicated that less than 1% of our sample had blood levels above those recommended by the CDC. Furthermore, the mean blood lead level of this sample of 2.29μg/dL is comparable to the average blood lead level of 2.8 μg/dL found in the NHANES III study[4] for individuals in the United States and is below the 4.3 μg/dL average reported in a recent study of rural children.[5] It should be noted that these averages for rural children are based on samples that included younger children than those included in the current sample. Thus, there is an increased likelihood of a higher average blood lead level because particularly young children are at the greatest risk for elevated blood levels. Nonetheless, these findings suggest that the population studied in the current research project appears to, on average, have current blood lead levels no higher than the normative rural child in the United States.

Several limitations of the current study should be noted. Most importantly, when considering the low incidence of lead poisoning in this area, the sample size of 102 children does not lend itself to conclusive findings regarding average blood lead levels or incidence of those with elevated blood levels. In addition, the results of this study are limited to children in mid-Missouri with the resources to travel to and attend a hospital based ADHD clinic.

An additional point that should be made is that many of these children were screened in middle childhood to late adolescence. Thus, this study only identifies blood lead levels at the time the behavioral problems have come to be identified in a clinical setting. This study in no way rules out the possibility that lead exposure in early childhood is related to the behavioral problems or learning difficulties commonly seen among the children in our clinic. Identifying young children with high blood lead levels may be important in preventing some behavioral and learning problems. Thus, the current finding should in no way dissuade pediatricians from following the blood lead level screening recommendations set forth by the CDC.[3] These recommendations are as follows:

- ✔ All children should be assessed for high risk of lead exposure at each visit by asking screening questions.
- ✔ Children determined to be at high risk for lead exposure based on screening questions should have blood lead levels measured at the age of 6 months.
- ✔ Children determined to be at low risk should have blood lead levels measured at 12 to 15 months of age. MoMed

The Authors

Thomas D. Eppright, MD, *is an Assistant Professor in Child and Adolescent Psychiatry at the University of Missouri-Columbia.* ***Ellen Horwitz, PhD,*** *is an Assistant Professor of Child Health at the University of Missouri-Columbia. Both are co-directors of the Attention Deficit Hyperactivity Disorder Clinic at the University of Missouri Hospital and Clinics.* ***Sarah Vogel, MD,*** *was a medical student at the University of Missouri-Columbia at the time the paper was initially written.* ***Heather Tevendale*** *is a Graduate Research Assistant in the Department of Psychiatry/Neurology and is a clinical psychology doctoral candidate in the Department of Psychology at the University of Missouri-Columbia*

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MSMA forms Physicians Resource Network

Patrick J. Mills, MBA, CPA

The creation of Physicians Resource Network, L.L.C. (PRN), the MSMA-endorsed management services organization, allows physicians to take control of their medical decision-making by offering a comprehensive array of business and financial services.

PRN was announced during the MSMA Annual Convention in Kansas City by Daniel O'Sullivan, M.D., 1996-97 President of MSMA. PRN is a joint venture between Missouri State Medical Services (MSMS) and the Saint Louis Management Group (SLMG). It will offer access to the entire spectrum of services from which today's practicing physicians will benefit.

"Physicians have been asking - when are you going to do something about managed care?" said Dr. O'Sullivan. "PRN and the MSMA-supported managed care legislation (HB 335) go a long way to answering that."

Most physicians can relate to revenue limitations over the past few years combined with increasing administrative expenses resulting from managed care. PRN will assist MSMA members in increasing revenues and bringing expenses under control.

PRN will compliment the efforts of MSMS's Executive Vice President Tom Bennett, whose focus is organizing groups for managed care contracting. Michael Wood, President and CEO of SLMG, specializes in managing the ongoing operations of IPA's. Currently, SLMG manages 30 IPA's and other physician-owned entities within a six-state area. When PRN becomes fully operational in July, additional partners, each with their specific area of expertise, will have been credentialed by PRN to ensure MSMA members are purchasing services from experts with records of successes. Taken as a whole, PRN will be a virtual MSO representing experts in their particular field, such as capital projects, business development, network management, medical management, quality management, financial management, practice management, risk management, group management, and management information (computer) systems.

The MSMA realizes that physicians have relationships built on trust with their attorneys and accountants, much like physicians have with their patients. PRN wants to provide experts to assist, not replace, local professionals in working through the contractual maze known as managed care.

PRN will also focus on group purchasing arrangements such as cellular phones and office equipment. Also in the near future, PRN will announce an electronic claims preferred arrangement. PRN is designed to add tangible benefits to your MSMA membership.

The MSMA Council approved the formation of an MSO at its June 1996 meeting in response to Resolution #5 from the 1996 Annual Convention. The intent in creating an MSO is to assist physicians in managing managed care. The commission which studied the issue reported that an MSO would give them the tools they need to work within the framework of managed care. MoMed

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AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs.

Due to unexpected problems occurring with a new computer program at the AMA, this report has been delayed. Barring any more problems, this report will be featured monthly in *Missouri Medicine.*

December 1996

Victor Albera, Saint Clair
Arthur Daus, Joplin
Theodore DeFeo, Kansas City
Robert Dever, Joplin
George Devins, Kansas City
Edward Dewein, St. Louis
Joseph Eades, Chesterfield
Thomas Egan, St. Louis
Stephen Halpin, Hannibal
Sally Hubbard, Springfield
Edward Jenkins, Waynesville
Debra Koivunen, Columbia
Richard Nelson, Kansas City
Laghaieh Rezvani, Sikeston
Philip Shanahan, Creve Coeur
Brent Stromberg, St. Louis
Ernest Szabados, Independence
Edith Trugly, St. Louis
Gus Wetzel, Clinton
Daniel Whitman, Kansas City

January 1997

Benje Boonshaft, St. Louis
Tai-Yong Chung, Poplar Bluff
Donald Clement, Kansas City
Marvin Cook, St. Louis
Uma Eachempati, Arnold
F. R. Esparrago, Monett
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Timothy Holekamp, Columbia
William Huffaker, Chesterfield
Yasuo Ishida, St. Louis
Patrick Johnson, Farmington
Robert Jones, Nevada
George Kichura, Chesterfield
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Thomas Reardon, Affton
James Shaw, Hermann
Charles Sherwin, St. Louis
Edward Skeins, Springfield
John Sullivan, Springfield
Soros Tungsiripat, Kennett

February 1997

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Robert Bieser, Cape Girardeau
Michael Blank, DeSoto
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Kenneth Derrington, Roach
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Walter Schroeder, Cape Girardeau
Charles Singleton, Kansas City
Ozoemenam Uketui, St. Joseph
Arthur Vogel, Kansas City
Earl Wipfler, St. Charles
Paul Young, St. Louis

March 1997

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Peter Smith, St. Louis
Paul Spence, Cape Girardeau
Micheal Steenbergen, Jefferson City
Herbert Strain, Kansas City
Mark Ward, Springfield
Robert Wheeler, Harrisonville
Newton White, St. Louis
Arlen Winsky, Springfield

Mary Ann Contogiannis, MD, a plastic surgery resident from Kansas City, was one of 50 outstanding young medical professionals honored by the AMA at its annual National Leadership Conference. She received the AMA/Glaxo Wellcome Achievement Award for her service on the AMAs Board of Trustees as Resident Physician Trustee. During her two terms of service she was appointed President of the AMA Physicians Health Foundation and Vice President of the AMA Education Research Fund and served as the Resident Representative to the Accreditation Council for Graduated Medical Education.

James P. Youngblood, MD, of Kansas City, has been elected the President-Elect of The American College of Obstetricians and Gynecologists (ACOG). He will serve for one year as ACOG's 49th president, beginning in April 1998. Dr. Youngblood is a professor and chair of the department of obsetrics and gynecology at the University of Missouri-Kansas City School of Medicine, and director of the residency training program for Truman Medical Center and Saint Luke's Hospital in Kansas City.

In Memoriam

John M. Grant, MD, 70, St. Louis, died April 1, 1997. Dr. Grant, an internist, was a member of the Missouri State Medical Association.

Pedro Suarez-Solar, MD, 64, Chesterfield, died April 5, 1997. Dr. Suarez began practicing psychiatry in St. Charles County in 1973. He was instrumental in the development of psychiatric units at St. Joseph Health Center in St. Charles and stress and chemical dependency programs at Barnes-Jewish Hospital in St. Peters. Dr. Suarez was a board member of Youth in Need. He worked with the Cuba Relief Program to help families in the St. Charles area. In January 1997, the Gault Foundation recognized him for his community contributions. Dr. Suarez was a member of the Missouri State Medical Association.

Frank J. Valach, MD, 78, St. Louis, died April 7, 1997. Dr. Valach, an obstetrician and gynecologist, was a member of the Missouri State Medical Association.

Robert M. Drisko, MD, 80, Kansas City, died April 14, 1997. Dr. Drisko was an orthopedic surgeon and businessman in the Kansas City area for 50 years. He earned his medical degree from the University of Kansas. He interned in Syracuse, NY, and completed specialty training in orthopedic surgery at Columbia University Presbyterian Medical Center. He was a member of the Metropolitan Medical Society of Greater Kansas City, the Missouri State Medical Association, the American Medical Association, and the American Academy of Orthopedic Surgery.

Nicholas S. Vitale, MD, 90, Florissant, died April 15, 1997. Dr. Vitale, a surgeon, was a member of the Missouri State Medical Association.

Joan Goebel, MD, 90, St. Louis, died April 16, 1997. She was in private practice in St. Louis for 30 years. She graduated in 1927 from Trinity College in Washington and received her medical degree in 1932 from the University of Michigan Medical School. In 1971, she did volunteer work in Ghana, where she taught anesthesiology to the medical mission sisters and served as a consultant. In the mid-1980s she received an Athena Award from the University of Michigan for professional distinction and humanitarian work. She was a member of the Missouri State Medical Association.

John Bauer, MD, 81, St. Louis, died April 18, 1997. Dr. Bauer received his medical degree from Marquette University. Dr. Bauer, a pathologist, was a member of the Missouri State Medical Association.

Felix G. Solomon, MD, 71, St. Louis, died April 21, 1997. Dr. Solomon, an anesthesiologist, was a member of the Missouri State Medical Association.

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9 thru 11 - *St. Louis*: Strengthening Instructional Skills. Call 1-800-553-2712.

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Tobacco Wars

J. Regan Thomas, MD

Legislative and judicial components of the "tobacco wars" continue to confound and surprise most interested observers. Recently a class action suit by former airline flight attendants was brought against the tobacco companies. This was of particular interest because it was the first such action to be pursued based on exposure to "second-hand" smoke. Some feel this would be an especially strong case since those alleged to be injured are people who did not necessarily participate willingly by deciding to smoke themselves. Most of the studies on second-hand smoke have been directed at the children in smoking households. This new attention to second-hand smoke exposure by workers in an extremely captive environment will highlight some very interesting debate.

In spite of all this continuing litigation and media attention, our young people continue to smoke at increasing rates. This column has discussed at length previously the impact of advertising on smoking, especially with teenagers. The Liggett Group (a cigarette manufacturer) recently split ranks with other tobacco companies and admitted among other things that teenagers are targeted by advertising. Although the companies continue to argue that the Joe Camel-like promotions are not aimed at teens, the three most heavily advertised cigarette brands (Camel, Marlboro, and Newport) are also the three most popular brands with teenagers.

About one in four Missouri high school seniors reportedly smokes. Although some Missouri communities are strengthening their regulations regarding cigarette sales to minors, tobacco products remain easily accessible. Many retailers simply are not willing to accept the responsibility to refuse sales to minors in the face of lost profits or heightened scrutiny of their young customers. I spoke before a county government group last year that was considering stronger regulations banning cigarette sales to minors. I honestly thought it would be a non-controversial issue and that the facts and the issue would in effect speak for themselves. I was amazed at the resistance to the concept. Arguments about the slim profit margins of small retailers that depended on cigarette sales (even if it meant selling to minors) and vague arguments about parental responsibilities instead of community standards and regulations seemed to have significant impact on the committee. Many times what we believe are the straight forward facts about health issues are not always as important as other economic and political issues in the real world.

Many times what we believe are the straight forward facts about health issues are not always as important as other economic and political issues in the real world.

There is some interest and momentum for higher cigarette taxes in Missouri. Missouri apparently has the tenth lowest tax on cigarettes in the country. A recent editorial comment in the *St. Louis Post Dispatch* stated that a 75-cent-a-pack cigarette tax "would cut the youth smoking rate in half." In addition to making cigarette purchases somewhat more prohibitive to young people, perhaps proceeds could be used to counter the marketing and promotional activities of the tobacco industries.

I hope that all the legal and regulatory activities; the discussions about profits, promotions, and even moral aspects of tobacco use and the tobacco industry, do not overshadow the real issue. Tobacco use is a major health problem for our nation including our children. This underlying concern about health should be the fundamental premise for all these activities. Any defense of the status quo for the use or sale of tobacco products should not overlook that fundamental. MoMed

Physician Leadership – Expanding the Role

Deborah Ann Jantsch, MD
7th District Councilor
Metropolitan Medical Society of Greater Kansas City

The traditional role for physicians has always been, and will continue to be, one of primary responsibility to the patient. This relationship to a single individual is at the very core of our value system.

Today, many physicians are involved in expanding the traditional role. Physician managers are emerging in all aspects of health care delivery. These doctors are developing a bigger picture. A picture that involves the management of the health of their populations, the health promotion in their community, and the stewardship of resources. At the same time, these physician managers must preserve the balance for the individual patient.

Success in this new journey is not a given. Physician leadership was not a course I was offered in medical school. When I finished residency in 1990, health care policy was not an issue that I used, even remotely, to plan my career. Seven short years later, I have come to realize that the expanding role of the physician advocate may be the defining challenge for my lifetime in medicine.

The Missouri State Medical Association has developed physicians as leaders throughout its long and dedicated history. As our organization moves toward the twenty-first century, we will have an opportunity to write new chapters. We will deal with expanding roles and we will deal with all the difficult issues that change brings to our table. First, we must leam to fully appreciate the journey of leadership.

The inaugural session of the Missouri Physician Leadership Program was held May 15-18 in Wright City. Twenty-six physician participants attended from around the state. These doctors came from private practice, the public sector, many specialties, and with a diversity of hybrid-type roles they are currently developing in their communities.

The program was presented by the University of Missouri-Columbia School of Medicine Departments of Mental Health, Health Service Management, Family and Community Medicine, and Psychiatry and Neurology. A team of national consultants in health care leadership was also utilized. This team was comprised of Leadership Innovation Associates, in conjunction with, The Pew Center for Health Professions and Triangle Associates.

MSMA was invited to send representatives to the inaugural session and six members of our organization were involved in all the activities of the four-day program. Members who attended were: A.J. Campbell, MD, MSMA President, and five representatives of councilor districts, James Wolfe, MD; Meredith Payne, MD; Gordon Goldman, MD; Jerry Kennett, MD; and Deborah Jantsch, MD.

I'd like to share with you the highlights of each day.

Day 1

Prior to the conference, we completed an individual personality assessment that allowed us to understand our leadership styles and how they would best benefit our organizations. Manager styles were described as: traditionalist/judicial, troubleshooter/negotiator, catalyst, and visionary. There are strengths and weaknesses of each of these styles, but they all provide value in a team approach to problem solving.

The afternoon session provided an interesting exercise in team effectiveness. We were divided into groups with the task of negotiating managed care contracts. Some of us were doctors and others were health plan representatives. Even in a simulated exercise with a very short time span, many of the problems of real life emerged. My group was not able to negotiate a contract that we thought was in the best interest of our pretend doctors back home. We lost marketshare and were never able to regain advantage in the system.

Day 2

Another tool we provided prior to the conference, was an assessment from members of our home organizations about our personal leadership skills in the office. The home folks also provided their take on the characteristics of an ideal leader for their office. Obviously, this feedback provided opportunities to look at ways to improve our management in our current settings.

By afternoon, we were again involved in negotiation of contracts. This time we could form mergers and better position ourselves. We were forced to work together to meet goals. In true physician fashion, once we understood the exercise, and the fact that you got points for negotiating a contract, we became very agreeable with the terms. This day was ruthless with false rumors about alliances and exclusive contracts. The take home lesson was keeping your wits about you while your world was being tumed upside down.

Day 3

The invited speaker, Coleen Kivlahan, MD, MSPH, focused on the issues of leadership for change and what it is about physicians that often makes us fail as managers of change.

We received our last feedback from home about our ability to effect change in our home organizations and what issues our home office was asking for in the way of change.

Next, was an exercise in peer coaching. We presented a problem in our own real life situations to several of our conference colleagues and asked for ideas on solutions. Asking for feedback early and often was the lesson of this day.

Day 4

On this day, leadership was demonstrated by example. Five physicians made up a panel and told about their own journeys into leadership roles, the choices they made along the way, and the effect it had on their lives.

In closing, we created report cards which were individual in terms of personal goals with respect to leadership. We will have the opportunity in the future to grade ourselves on how effectively we are changing to meet those goals.

When I left Wright City, I had met a group of physicians who had come a long way in becoming more comfortable with the expanding role of the physician advocate. The choice to become a leader or a manager is not always a natural one. Our changing world is not what we expected. Our changing role is not what we trained to become. When a physician emerges as a leader, it may not be the best for his or her personal timing. We need to be able to recognize timing but we don't always get to choose it. Sometimes, it is a matter of necessity.

The physician leader has a unique set of circumstances. Our lives are already too busy, too overwhelming, and too committed. There will always be one more phone call, one more meeting, one more frustration, one more disruption, and one more challenge. It is the highest pinnacle and the lowest depth. We have our core values. Before long, we must learn to appreciate the journey of leadership.

With thanks to the:

- Principle faculty - Robert L. Williams, PhD; Coleen Kivlahan, MD, MSPH; and Marc T. Frankel, PhD
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- Other faculty - James Slaughter, MD; Betsy Garrett, MD; W. Kirk Nichols, MD; Gary Sluyter, PhD, MPH; Steven Zweig, MD; Maureen Dempsey, MD; Danny Wedding, PhD, MPH

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Allergen Immunotherapy

Mark L. Vandewalker, MD, FAAI

As an asthma specialist in Columbia, I read with great interest the article, "Are You Missing the Boat in Modern Asthma Therapy?," published in the *Missouri Medicine* May 1997 issue. This is an excellent and readable review of an often difficult to manage chronic illness. However, I must disagree strongly with the answer to questions #5 – "Should I be sending more of my asthma patients for allergen immunotherapy?"

The article cited stating that allergy shots do not help most asthma patients was written by Peter Barnes in last year's *New England Journal of Medicine.* Dr. Barnes is a brilliant man who practices pulmonary medicine in a country where immunotherapy injections are not prescribed. Therefore, I doubt he has much experience in understanding the efficacy of specific allergen treatment for patients with allergic asthma.

A more appropriate article that questions the efficacy of immunotherapy in asthma was published in the January 30, 1997, issue of the *New England Journal of Medicine* by Adkinson, et al, from Johns Hopkins Medical School. These physicians were unable to show that adding immunotherapy to the regimen of children with moderately severe asthma, who were otherwise undergoing intensive medical follow-up and treatment for their disease, offered any additional benefit. Both the American College and the American Academy of Allergy, Asthma, and Immunology have presented outstanding critiques of this article. It is obvious that frequent ongoing care by board-certified specialists in treating asthma is the very best treatment for the vast majority of moderately severe cases regardless of whether or not immunotherapy is employed.

A much more relevant analysis of allergy shots in asthma was published in the *American Journal of Respiratory and Critical Care Medicine*, Vol. 151, pages 969-974, 1995. In this article, Dr. Abramson and his colleagues performed a meta-analysis of 20 randomized, placebo-controlled, double-blind trials of allergen immunotherapy for asthma. The meta-analysis clearly shows that allergy shots improve a number of variables of asthma to include reduction in medication, decrease in bronchial hyperresponsiveness, and improvement in pulmonary function (a mean increase of 7% FEV1).

Obviously, the bulk of scientific evidence in the literature supports the use of allergen immunotherapy in the treatment of extrinsic (allergen induced) asthma, when prescribed by a board-certified allergist comfortable in the management of complex antigens and possible immunotherapy reactions. MoMed

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PRN - Assisting Physicians in Managing Managed Care

A.J. Campbell, MD, MSMA President

One of my goals this year is to help all of us as physicians manage under managed care.

In order to do this effectively, we must continually inform ourselves regarding managed care and our various options. The Missouri State Medical Association and Missouri State Medical Services, a subsidiary of MSMA, have explored the development of a statewide medical service organization to help us. The creation of Physicians Resource Network (PRN) is a joint venture between MSMS and Saint Louis Management Group, a health care management and consulting firm.

PRN will provide physicians with different interests, geographic locations, and practice sizes with access to carefully screened, high caliber business and financial services and products in a cost-effective manner. PRN participants can be solo practitioners, physician group practices or integrated physician entities.

PRN partners will facilitate multiple organizational activities such as the formation of integrated medical groups which include independent physician associations (IPAs); group practices without walls, and medical practice mergers and consolidations. It can also provide access, expertise, and financial and operational support to the physician at the individual or medical practice level. There are more than 50 core partners being considered for participation in PRN.

> **These companies have met stringent performance standards and criteria and are endorsed by the Missouri State Medical Association.**

Michael A. Wood, CEO of Saint Louis Management Group, states, "The caliber of prospective core partners and their level of interest in participating in PRN has been impressive. Their desire to collaborate with other physician service companies will be a key success factor for PRN."

These PRN service offerings are being created through the collaboration of multiple physician services companies located throughout Missouri. These companies have met stringent performance standards and criteria and are endorsed by the Missouri State Medical Association.

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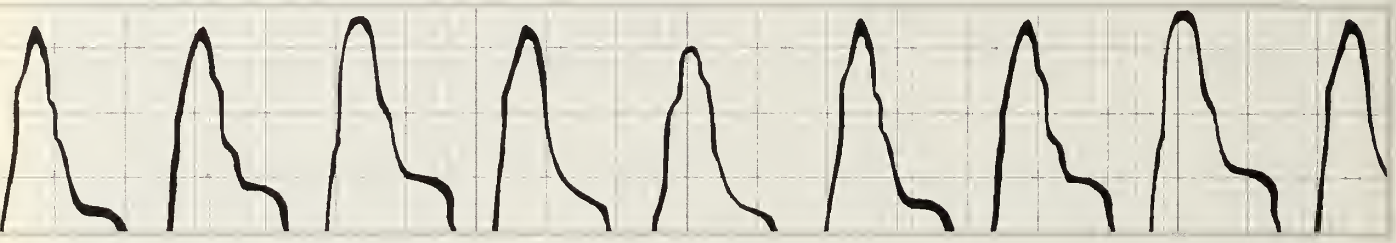

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"Partners in Caring"

Becky Moore, MSMA Alliance President

This year, my theme for Medical Alliance is "Partners in Caring." To be a partner in a relationship requires commitment, communication, and participation. Whether we are referring to a partnership in our marriage, our family, or our organization, all of these elements must be present for our partnership to survive and grow and all parts must function for success.

Commitment implies trust and sharing, as well as giving and receiving on both sides. At times in medical marriages, there can be more giving on one side than the other. When this happens, a break in the relationship can occur. Medical families require that all the members commit to work for the good of each other. When there is a weakness in the commitment, all suffer. It is true that a chain is only as strong as its weakest link. Our strength in our marriages, families, and organization begins with our commitment to care and be concerned for each other.

Communication is essential in a partnership. We cannot expect our partners to read our minds or hearts. Communication reinforces our commitment to each other. Many marriages are destroyed because communication has broken down. Medical Alliance is committed to help bridge these family relationships. Because of the different personalities involved in a family, clear communication is required among the members. If communication doesn't transpire, walls build up, feelings are trampled, and relationships break down. A healthy family relationship requires frequent communication, tolerance, and a good measure of forgiveness.

An organization such as Medical Alliance also requires communication among the members. Though the commitment level is different than in a family, it is just as important to keep communication lines open. Our commitment to this organization requires that we evaluate its worth in our lives. Currently, the Medical Alliance has a task force committed to nurturing the medical family. Programs are being planned that we hope will strengthen our medical family. The first activity will be at Big Cedar Lodge, October 23-24, 1997.

Participation in the medical marriage, the family, and our organization requires time and effort. When we invest time and effort to participate in these relationships, we invest the best part of ourselves. Part of us becomes a part of that entity because of the value at which we placed it. The more you give to anything, the more you will get out of it. At different times in our lives we can only invest a small part of our time and energy, whereas other times we can give more. This requires an agreement to communicate with others so a balance can be maintained.

This year the Medical Alliance is committed to strengthening the partnership in our marriages, our families, and our organization. The questions is, will you commit, communicate, and participate to strengthen your families and your organization? Please take time to consider your role as a partner in your marriage, your family, and our medical organization. Our future in all of these areas depends on commitment, communication, and participation. MoMed

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Informing the Cancer Patient

Ralph Silverman, Medical Student
University of Missouri - Kansas City

In all areas of medicine, there are times when the physician must face the most disappointing task of telling his patient he has a life-threatening illness such as cancer. A dreadful task indeed, which in any case will leave the patient scared, anxious, and also curious. The physician must prepare himself rigorously so he has the strength to help the patient deal with this anxiety and curiosity. In the past, medical ethics has concerned itself with whether or not the physician should inform the patient about the diagnosis of cancer. Also, can the physician, the patient or both benefit from delaying the diagnosis of cancer or at least the specifics about the disease? These questions must be answered using a systematic yet logical approach, so each case is individualized and no detail is ignored.

To help individualize the cases of informing patients about the diagnosis of cancer, it is essential that the physician assess the situation. Is this cancer curable and can Mr. Smith be given some solid hope? Or is the cancer terminal in which case I cannot offer Mr. Smith solid hope for a cure?[1]

When the case is broken down into curable and incurable, the situation becomes more defined. If dealing with an incurable patient it is of the utmost importance that, "This patient must be warned in sufficient time of the danger of death to take care of his temporal and spiritual obligations."[1] It would be safe to say that any individual should be given the right to choose how he would carry out the last days of his life. Likewise, no man has the power to decide this for another man. Withholding this information from the incurable patient is immoral and also illegal. Indeed the courts have ruled in several cases against physicians who either did not tell the patient of the incurable nature of the disease or told the patient he would get better in time even though his illness was terminal.[1]

While telling the incurable patient of his condition and fate is an obligation, does the physician have an obligation to tell the patient of the precise nature of the disease? In other words, is the physician required to tell the patient that her breast cancer that has already invaded multiple axillary lymph nodes and is now causing back pain, will then proceed to infiltrate her leg bones and liver causing severe pain as well as nausea and vomiting? Is it necessary the patient be told that with chemotherapy, radiation or surgery, her chance of surviving the cancer is zero? Indeed it is not necessary to inform the patient of these events and statistics.[2] What is necessary is that the patient should know her life will end soon and no medical treatment can cure her disease. If the patient has been informed of the diagnosis and in enough time so temporal and spiritual obligations can be taken care of, the physician's moral obligation is fulfilled.[1]

The curable patient presents a different schema for the physician. While the physician needs to focus on the specific treatment for the particular cancer, he also needs to keep the patient in a positive state of mind so the treatment can be carried out in a cooperative effort. This being the idea, it may be beneficial to withhold the diagnosis until a plan of action is mapped out. Likewise, when the patient is informed and treatment is to begin, the precise nature of the disease may be withheld.[1] There is a subset of patients who when informed of their diagnosis and given solid hope to stand upon, will focus their energy on recovery and cooperating so that the best treatment be given. Then there is a smaller subset who, when informed of their disease and given solid hope for a cure, become dejected and refuse to cooperate, believing that all roads lead to failure.

These being the two subsets usually confronted with, the physician must decide which category his patient best fits into. If the patient is a suspect of being uncooperative and despondent, the physician may delay with informing the patient about the gravity of the diagnosis.[1] In this way, the physician is really looking out for the

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best interests of the patient. An unknowing yet cooperative optimistic patient will travel faster toward the cure than the knowing yet uncooperative and pessimistic patient. If a physician decides not to specify upon the gravity of the cancer in a curable patient, suspecting that he will be uncooperative and dejected, he must inform the patient of the gravity if the cancer were to progress to an incurable state. This of course will allow sufficient time to tie up all loose ends before completing life's final chapter.

With a curable patient, the physician must always measure the steps forward and steps backward so he is constantly assessing the patient's prognosis. If the once curable patient were to develop extensive metastasis, thus rendering him terminal, the physician would be obliged to inform the patient of this for reasons previously discussed. The physician must forbid himself to create false hope for the terminal cancer patient. "To hold out this kind of hope is too frequently a deception, which in the long run proves more often to be a disservice than the promised victory it seems at first."[3]

While cancer is prevalent in our society, the methods and attitudes we use to deal with the diagnosis can vary from person to person. No one cancer patient has the same understanding or rationality of this disease. It is thus the duty of the physician to assess and individualize each and every cancer patient he treats. By separating these patients into curable and incurable categories as well as their subsets, the appropriate yet logical method in approaching the patient with cancer becomes more lucid. While the thought process and assessment of the cancer patient may seem cumbersome, in the end, it is the dignity and well being of the patient that the physician strives to maintain even while facing the loss of life. MoMed

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U.S. Supreme Court and Federal Trade Commission Determine Medicine is Not a Profession

Decision Affects Patient Care

Arthur H. Gale, MD

When did physicians cease being professionals and become mere purveyors of commerce? When did physicians become providers and patients become customers? Who is responsible for physicians' no longer being advocates for their patients' health, while working under the perverse financial incentives of capitation which reward them for withholding care?

Most persons would probably answer that these changes in the practice of medicine were brought about gradually over the past decade or so by business and insurance interests in order to lower costs. That answer is not correct. The prime movers for these changes were the U. S. Supreme Court and the Federal Trade Commission (FTC). The year in which these changes began was 1975.

In 1975, Lewis and Ruth Goldfarb contracted to buy a home. This required employing an attorney to conduct a title examination. All of the lawyers whom they contacted charged a similar fee. The Goldfarbs filed suit contending that the Virginia State Bar and local bar association conspired to restrain interstate commerce through the use of fixed fees. The case went all the way to the U.S. Supreme Court. The Court ruled in favor of the Goldfarbs.

The Goldfarb suit did not directly involve any physician or physician organizations. Yet it was to become a landmark decision with devastating effects on the medical profession.

The court ruled that henceforth the learned professions, law and medicine were to be treated like any other commercial activity and were not exempt from antitrust. All of the changes in the practice of medicine over the past two decades can be traced to that one decision. Most doctors have never heard of it.

As pointed out by Kuttner (*New England Journal of Medicine,* Jan. 30, 1997), the Court's position on the medical profession was best summarized in an amicus brief for the plaintiffs filed by a prominent antitrust law professor. The brief included the following statement, "The success of the medical profession in controlling the economic environment of physicians from the 1930s to the 1980s...was arguably the most successful restraint of trade ever perpetrated by private interests against American consumers."

Now, more than two decades after the Goldfarb decision, and with managed care the dominant form of health care delivery, some of the original supporters of the Goldfarb decision are having misgivings. Because of the commercialization of the medical marketplace by the giant for-profit HMOs, the trust which has traditionally existed between patient and doctor has eroded. This trust has been replaced by the credo of the marketplace–"caveat emptor" or buyer beware.

The naive assumption by the Supreme Court that the profession of medicine could be treated like any other commercial activity is belied by the rising tide of public outrage against the abuses of managed care. The recent passage of the managed care bill, HB 335, by the Missouri legislature is just one of many pieces of legislation introduced in the U.S. over the past several years attempting to regulate these abuses.

The Goldfarb decision was wrong because it transferred control of patient care from the medical profession with its code of ethics dating back to the Hippocratic Oath, to the FTC and, to a lesser degree, the Department of Justice, Antitrust Division.

An FTC attorney (*New England Journal of Medicine,* Oct. 3, 1985) wrote, "The FTCs responsibility is to preserve and foster competitive opportunities and consumer choice in the marketplace..." Most physicians, I believe, would not quarrel with that definition of antitrust. Physicians are not afraid of competition based on cost and quality.

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There are, however, significant problems with physicians' ability to comply with the FTC goals. First, under managed care, "competitive opportunities" exist only for insurance companies competing for the business of employers, not physicians competing for the business of consumers. Second, there is virtually no "consumer choice." The consumer (employee) is auctioned off once a year like a commodity to the HMO tendering the lowest bid to the employer. Third, the medical "marketplace" is unnatural because of third party payers; it is not a marketplace of individual consumers freely making choices based on quality and cost, as intended by the FTC statement.

In 1979, the FTC filed a successful antitrust suit against the AMA over the AMAs "anti competitive ethical restrictions" on free choice of physician, compensation on a non fee-for-service basis, the corporate practice of medicine and truthful advertising. The term "non fee-for-service" is a euphemism for capitation. Three years later the FTC issued a restraining order preventing the AMA Council on Ethical and Judicial Affairs (CEJA) from even issuing a non-binding opinion on the ethics of capitation which involve withholds and bonuses. And more recently the FTC has issued rules preventing physicians from forming networks unless the doctors assume financial risk for patient care.

The FTC brooks no dissent on the ethics of capitation, withholds, bonuses, physicians at financial risk, and the harm to patients which these practices may cause. The FTC has effectively silenced its critics in organized medicine by threatening the AMA with a lawsuit if it spoke out against the ethics of capitation. The FTC dismissed the AMAs ethical concerns about capitation as just a ploy to preserve the economic interests of its members.

Thus we are witness to the FTCs transformation from a regulatory agency charged with enforcing free and open competition to becoming a laboratory for social engineering. The FTC has decided on its own to impose a revolutionary and untried system of capitation on the American people without their prior informed consent.

The FTC has one all consuming goal–to lower health care costs. As such, the agency's position is essentially amoral. It chooses to ignore the possibility that this new system of capitation carries the potential of harming patients. It ignores the possibility that financial incentives in the form of withholds and bonuses can affect patient care by denying appropriate tests, procedures, and physician referrals.

The justices who wrote the majority decision in the Goldfarb case and the Congressmen who enacted the Sherman Antitrust Act of 1890, as well as those persons in the Woodrow Wilson administration who created the FTC, probably never heard of capitation or envisioned the role of the FTC in promoting it.

Now we are beginning to see capitation under attack by the public, the media, ethicists, the legal profession, and the courts. The public is beginning to recognize the fallout from capitation as practiced by managed care companies–poor patient care, denial of benefits, and lack of accountability.

The managed care industry has foolishly and unsuccessfully used gag rules in an attempt to conceal capitation and its perverse financial incentives from the public. By imposing gag rules on doctors, managed care virtually admits it is doing something wrong–something that it doesn't want the public to know about.

The FTC has provided no antitrust remedy for the abuses against consumers by managed care companies. And under ERISA, the law which covers 50% to 60% of employed persons in the U.S., injured parties have no right to redress their grievances against managed care companies through the courts.

The FTC cannot dismiss public concern over the ethics of capitation as it has physician concern by threatening a lawsuit against the AMA. An aroused public opinion is forcing the FTC and its supporters to reassess its position on capitation and doctors assuming financial risk.

Administrative agencies like the FTC are supposed to be a part of the executive branch of government administering laws passed by Congress. In fact they often act like a fourth branch of government wielding enormous power, making new rules which differ significantly from the intent of the original laws passed by Congress.

Administrative agencies are often unaccountable until they step out of line too far and Congress has to pass additional laws to rein them in. This actually happened in the last Congress when the threat of legislation (Hyde) forced the FTC to change its policy on physician sponsored networks.

Ultimately it is the public who will render the final judgment on our present system of health care delivery spawned by the Goldfarb decision as interpreted and implemented by the FTC. In our system of government it is the people who are the final source of authority. If the public becomes disenchanted with the major features of managed care-capitation, perverse financial incentives, gag rules, and lack of consumer choice and protection, no branch of government can prevent its collapse. **MoMed**

Radiology Quiz #13

Roger A. Francis, MD
Radiology Department, Lake of the Ozarks General Hospital

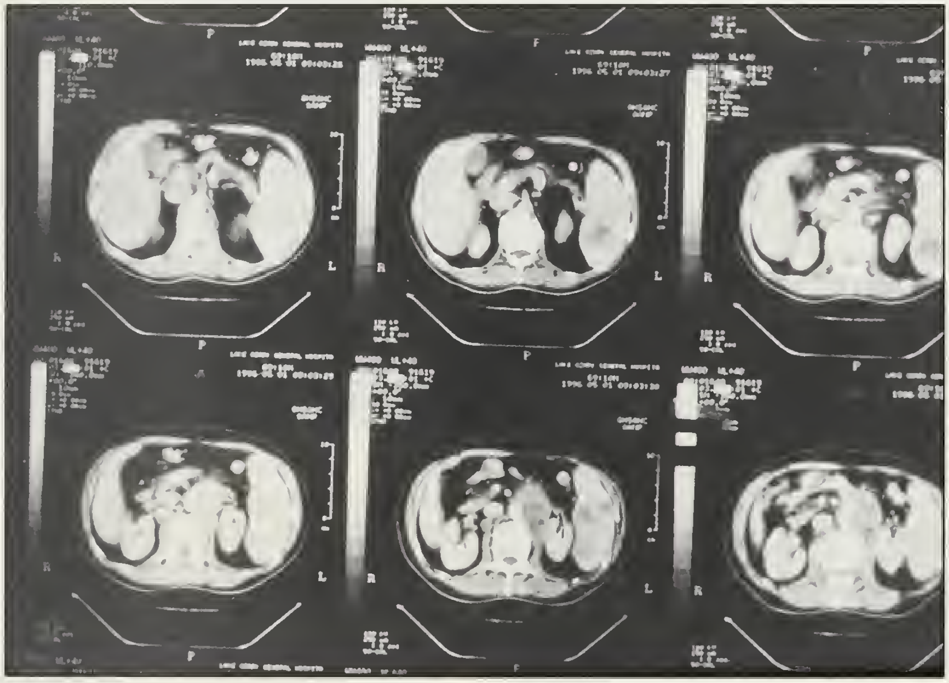

Figure 1

A 69-year-old male was admitted to the hospital with a several week history of epigastric pain, nausea, vomiting, and 20 pound weight loss. As part of the workup, a CT scan of the upper abdomen was performed (Figure 1). Which of the following is the LEAST likely diagnosis?

What is the LEAST likely diagnosis?

a. lymphoma
b. metastatic carcinoma
c. soft tissue sarcoma
d. psoas abscess

(See answer on next page.)

The Radiology Quiz question is located on the previous page.

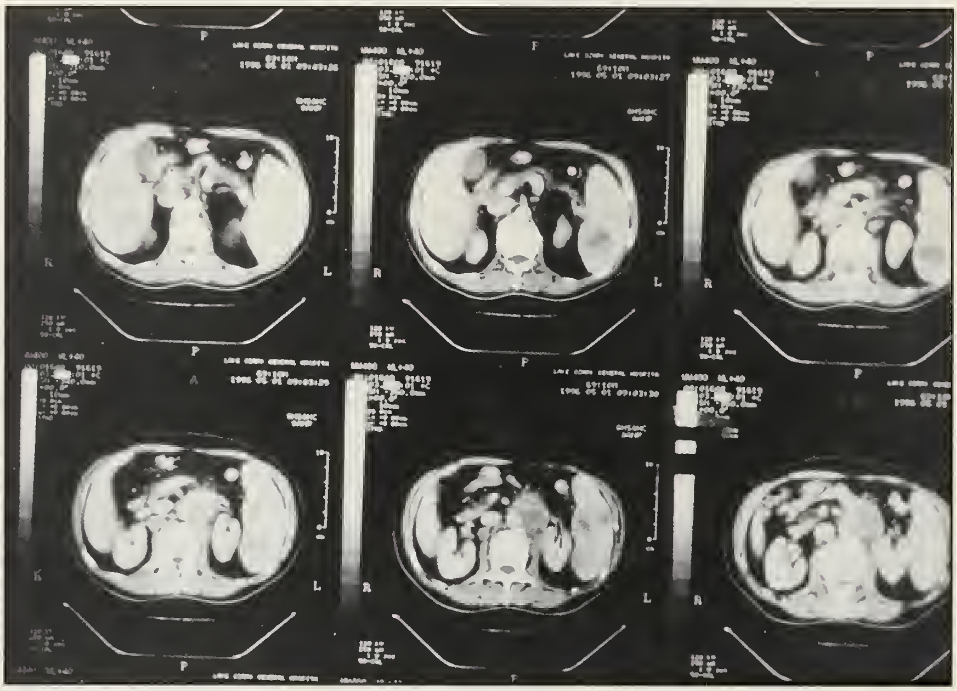

Figure 1 repeated

ANSWER: d. psoas abscess
DIAGNOSIS: a. lymphoma

CT slices (Figure 1) show multiple low attenuation masses (small arrows) in the liver and spleen. There is is also an irregular mass (large arrows) in the left periaortic region, partly involving the left psoas muscle (P). This probably represents a mass of enlarged lymph nodes. Differential possibilities for psoas mass, enlarged lymph nodes, and masses involving the liver and spleen include lymphoma, metastatic carcinoma, and soft tissue sarcoma with metastases. Psoas abscess could cause the psoas mass, but would not explain liver and speen masses. Psoas abscess would therefore be the LEAST likely diagnosis, and is therefore the correct response. The patient underwent a laparoscopically guided incisional biopsy of a liver mass which showed a malignant lymphoma, type unclassified.

There are several imaging modalities which have been used for abdominal staging of lymphoma. Prior to CT scanning, lymphangiography was the only imaging modality which could clearly depict lymph nodes and detect abnormalities. Gallium scintigraphy has also been helpful by showing uptake in lymphomas and some carcinomas. However, CT scanning gives superior anatomic visualization or abdominal anatomy, including the presence of organomegaly, masses and enlarged lymph nodes. CT is limited by the fact that lymphoma may be present in organs and nodes without causing enlargement or discrete masses. Magnetic Resonance Imaging (MRI) shows promise in visualizing lymph node enlargement, but this is not widely used in abdominal staging due to expense and motion in the upper abdomen. Despite a large number of false negatives, CT remains the imaging procedure of choice for abdominal staging of lymphomas.

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Medical Malpractice

The Defense Perspective

David P. Ellington, MA, JD
Robert S. Rosenthal, JD, MS

In the 1970s, medical malpractice claims threatened the availability of professional liability insurance.[1] Some insurers eliminated medical malpractice coverage and some physicians began to experience difficulty in obtaining insurance coverage.[2] As a result, many physician-owned insurance companies formed in the late 1970s and early 1980s to address this problem.[3] Moving into the 1980s, the frequency and severity of claims against health care professionals continued to rise.[4] As a result of this trend, the affordability of medical malpractice liability coverage became a significant concern.[5]

This nationwide trend and its ramifications were experienced in Missouri. In the early 1980s, malpractice carriers in Missouri were suffering loss ratios wherein the direct incurred losses were exceeding the direct earned premiums.[6] Carriers writing medical malpractice insurance in Missouri declined from 76 companies in 1984 to 46 companies in 1986.[7]

In 1986, the Missouri General Assembly enacted legislative reform to address the public concern over the increasing cost of health care and the continued integrity of the delivery of health care services.[8] Legislative reform has placed a limitation on non-economic damages recoverable in medical malpractice actions.[9] This cap on non-economic damages is adjusted annually in accordance with the Implicit Price Deflator for Personal Consumption Expenditures.[10] Currently, no plaintiff shall recover more than $502,000 per defendant for non-economic damages.

Statutory reform provides for the ability to satisfy future damages in periodic payments if the total damages exceed $100,000.[11] The payment of future medical damages terminates upon the death of plaintiff.[12] Missouri law now provides that in a

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The Plaintiff's Perspective

Stephen F. Meyerkord, JD

Is there a "medical malpractice crisis?" Physicians and trial lawyers will probably never agree on the subject. Medical malpractice reform legislation is introduced in Congress perennially. In 1986, the Missouri General Assembly enacted "tort reform" legislation imposing restrictions on medical negligence actions.[1] Proponents of the crisis theory suggest malpractice suits are overloading the courts, juries are returning excessive verdicts, and, as a result, malpractice insurance premiums are skyrocketing.

If a "crisis" ever existed, it has waned. Malpractice claims have decreased. Malpractice lawsuits have decreased. Average recoveries in medical malpractice cases have risen, but not as fast as health care costs. Health care professionals continue to prevail in the majority of malpractice claims which are tried to conclusion before a jury. The only thing that has skyrocketed is the profitability of medical malpractice insurance.

Even though Missouri has experienced a modest population increase since 1986,[2] the number of malpractice claims has decreased in the same period. Statistics released by the Missouri Division of Insurance in its Medical Malpractice Insurance Report in October 1996 indicate that the number of claims closed has been less than the 1986 total (2,069 claims closed) every year through 1995 (1,914 claims closed).[3]

In the City and County of St. Louis, the two largest judicial circuits in Missouri, medical malpractice lawsuits decreased 30% from 336 cases filed in 1994 to 234 cases filed in 1995.[4] The AMA has reported the number of malpractice claims nationally has dropped at an annual rate of 8.9% from 1985 to 1992.[5]

Average settlements and verdicts reached in medical malpractice cases have increased, but at a

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medical malpractice action, the plaintiff or plaintiff's lawyer shall file an affidavit attesting that a written opinion of a qualified health care provider has been obtained wherein the consulting expert states the plaintiff sustained damages as a result of a deviation from the standard of care.[13] The court may dismiss a malpractice action without prejudice to refiling upon the failure to file the statutory affidavit.[14]

Statutory reform has modified the rules of joint and several liability. A health care provider against whom an award of damages is made shall be jointly liable only with those defendants whose apportioned percentage of fault is equal to or less than such health care provider.[15] Prior to this modification of joint and several liability, a hospital or physician assessed 1% of fault could be required to satisfy the entire amount of the judgment.

The Supreme Court of Missouri has held that these legislative measures are legitimate efforts to address the concern of the availability and affordability of health care services and pass constitutional muster.[16] A majority of state legislatures in this country have enacted tort reform applicable to malpractice actions.

These legislative measures have seemed to create some stability in the medical malpractice insurance market in Missouri. Missouri had 54 companies writing medical malpractice insurance policies in 1995, the highest number since 1985.[17] The malpractice insurance market is largely homegrown with four of the top six companies domiciled in Missouri.[18] In recent years, physician-owned insurance companies have returned millions of dollars in premium credits to their policyholders.[19] Increasing competition in the marketplace for coverage and a reduction in premiums reflect that companies have experienced a more favorable loss experience than was the case in the past. This reflects that reforms may be working.

This level of stability inures to the benefit of health care professionals and the consuming public. Public policy should be guided by measures to assure essential health care services are available and not unduly burdened by excessive cost from medical malpractice claims. Of course, no one's interests are furthered in an environment where malpractice carriers operate marginally. When health care professionals are presented with a medical malpractice claim, they reasonably expect their insurance coverage is intact. It is also in the consuming public's interest that health care professionals have coverage which is not depleted or exhausted when claims are made. Prior to legislative reform in Missouri, some health care providers found that their carrier went bankrupt and were thus personally exposed to financial ruin when presented with claims.

The most recent data from the Missouri Department of Insurance shows that 1,914 claims were closed in 1995 which was an 8.9% increase from 1994.[20] Approximately 67% of claims were closed without any indemnity payments.[21] The average indemnity for physicians and surgeons on paid claims increased by $1,480 from 1994 to $155,981 in 1995. Insurance carriers spend an average of $19,070 per claim to defend.[22] In addition to the direct costs of litigation, many physicians feel compelled to perform procedures or tests which are done primarily to avoid malpractice exposure. Defensive medicine has been estimated to cost billions of dollars each year.

Missouri statistics that nearly seven out of 10 medical malpractice claims do not result in payment to the claimant are consistent with the national data. As the majority of claims are not proven to be meritorious, one considers what factors cause a patient to seek legal advice.

As with any human endeavor, mistakes or errors may occur and the practice of medicine is no exception. A patient may seek legal recourse when it is perceived that a mistake has been made which results in suffering and financial loss. This perception may be based on an error which is obvious to the patient, on admission by the treating health care professional, or it may be discovered by statements of a concurrent or subsequent medical care provider.

When a patient is damaged as a result of medical negligence, our tort system should provide fair compensation for the injuries. The vast majority of meritorious claims are settled without a trial. Of the 623 claims which were paid by Missouri malpractice carriers in 1995, 600 or 96.3% were settled.[23]

Unfortunately, health care professionals continue to be subjected to an unacceptable number of non-meritorious and unwarranted claims. Patients may seek legal advice to vent anger or frustration.[24] Experienced malpractice plaintiffs' lawyers have stated that as many as 95% of the patients who wish to pursue a claim are more upset about the manner in which they and their problems were handled than they are about the overall care provided.[25]

Claims may be made by patients who have unrealistic expectations as to what medical science and its practitioners can and cannot do and others believe the health care system can cure problems due to their own inattention to their own health or their unwillingness to follow the physician's treatment plan.[26] Some patients wish to blame everyone but themselves when they experience health problems which result from smoking or eating and drinking to excess against their physicians' advice to moderate their habits.

Another source of claims arise from disparaging remarks by other health care professionals. One medical malpractice insurance carrier found that 24% of its suits which ultimately closed without payment were instigated by uninformed, injudicious or careless comments made by concurrent or subsequent medical care providers.[27]

The medical records should not be utilized as a method of criticism of medical care elsewhere. While criticism and comment are extremely important in medical education and in providing good quality care, there are much better forums to express such criticism such as hospital committees, grand rounds, personal contact or peer review.[28]

We live in a litigious society. The tort system costs Americans billions of dollars each year in settlements, jury awards, and administrative and legal expenses. Our expenditures far exceed other major countries in the total dollars spent and as a percentage of the gross national product.

Lawyers are permitted by law to advertise their services to sue in malpractice. Emphasis is placed on attracting cases involving death, brain damage, paraplegia, loss of limbs, blindness or other severe permanent injury as those cases bring about the largest awards and justify the high cost of pursuing litigation. Newspapers highlight large plaintiffs' jury awards in malpractice cases but almost never report on any of the vast majority of cases that result in no finding of negligence. A segment of our population, fueled by media and advertising, turns to the plaintiffs' bar in our litigious society hoping to dig into a deep pocket when a medical complication occurs.

Regardless of why medical malpractice claims are brought, the majority are defended, not proven to be meritorious and result in no financial recovery by the claimant. The most recent data from the Missouri Department of Insurance shows that only about 4% of paid claims were resolved after full court proceedings and entry of judgment. While many of these settlements were reached because medical errors occurred, other factors may drive the health care professional to resolve a case short of trial.

The physician may seek a settlement to avoid the financial strain of closing their practice to attend the trial. This is particularly so in complex cases involving multiple retained and non-retained experts where the trial is expected to last a number of weeks. The physician may seek a settlement due to fear of personal financial exposure where the plaintiff's damages exceed the limits of liability coverage or a claim for punitive damages is made. As many states hold that punitive damages are not insurable and the physician would be held personally responsible, the plaintiff's attorney may sue for punitive damages with the hope that the physician would pressure his insurer to eliminate the personal financial risk.

Non-economic factors which may direct a physician toward settlement include the psychological and emotional rigors of defending a lawsuit to conclusion and the risk of adverse publicity. Although it may not be felt that malpractice was actually committed, the defense team must consider the affect of inadequate medical records, undue criticism of other treaters, well-credentialed experts, and sympathy for the plaintiff in predicting the jury's verdict. While it may be cheaper in the short term to reach quick settlements in questionable claims, the authors have found that particularly among well-established Missouri malpractice carriers, these claims will be vigorously defended even if it is less expensive to settle. Generally,

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physicians stand prepared to defend themselves against unwarranted claims. Physicians should understand that settlements are reported to managed care organizations, hospitals which grant staff privileges, state licensing agencies, and the National Practitioners' Data Bank.

When reflecting on our tort system, physicians may feel unfairly singled out. The law recognizes physicians are not responsible for honest errors in judgment and should be given great latitude in providing care.[29] However, this is often lost in sympathy at trial.

To be an "expert" in Missouri, one is not required to practice in the specialty or locality of the defendant physician or for that matter, have any experience with the care at issue. The "expert" can even have their license revoked and still provide testimony. In all cases, these "experts" have the benefit of hindsight. They are not generally held accountable in any way for their opinions and in most cases, handsomely compensated. It is often stated that physicians win more cases than are lost, but what is not stated is the cost both in dollars and emotional toll of withstanding a malpractice lawsuit. And even when the physician "wins" a lawsuit, the plaintiff owes the physician nothing. In that respect, the physician can only lose.

While tort reform has seemed to create some stability, more needs to be done. The law permits some circumvention of the tort reform provisions. Plaintiffs' lawyers commonly employ life care planners and economists who provide remarkable testimony that may overestimate the need for and cost of future care. Some plaintiffs' lawyers attempt to assert that a plaintiff is entitled to a separate cap on non-economic damages for each alleged deviation. Some assert that even though statutory reform limits the submission of punitive damages to the jury when the conduct is "willful, wanton or malicious," a lesser standard should apply to the statute. Plaintiffs continue to mount constitutional attacks on tort reform.

Physicians and surgeons continue to be subject to an unacceptable number of non-meritorious claims. The frequency and severity of malpractice claims traditionally rise and fall during a five-to-ten year cycle. Adequate reserves must be posted for future anticipated payments. Operating at a reasonable loss ratio allows carriers to provide reliable and affordable coverage. Missouri malpractice insurers paid 74 more claims in 1995 than in the previous year. Claims paid increased about 16% for physicians, surgeons, and hospitals in that time. The average indemnity for physicians and surgeons increased from 1994 to $155,981. Additional reform is warranted.

The collateral source rule prevents the defendant from introducing into evidence compensation received by plaintiff for an injury from a source other than the defendant. A collateral source offset would prevent plaintiffs from gaining a windfall–a double recovery from the physician and private insurance or benefits. Collateral source offsets have been shown to decrease malpractice costs. Some reformers propose limitations on punitive damage awards. The logic of this is seen when it is considered that such claims are often made to circumvent damage caps and to create fear of personal exposure rather than to deter a truly ill-intentioned physician. More suitable forums are in place for disciplinary measures. While many other reforms have been proposed, continued efforts must be pursued so physicians can defend themselves on a level playing field. MoMed

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rate less than the increase in the cost of health care over the same time period.[6] Missouri Department of Insurance statistics indicate that the average payment for claims closed from 1986 to 1995, in which some payment was made, rose from $80,444 to $128,194 per claim.[7] The average for all claims from 1986 to 1995, including those for which no payment was made, increased from $26,516 to $41,727.[8] The increase in average amount of settlements appears to be a result of the decrease in the number of minor injury claims filed and the screening process for filing same rather than a function of increased generosity. The decrease in medical malpractice claims reflects the economic reality that only catastrophic injuries justify the high cost of pursuing medical malpractice actions.

There is no excess of big verdicts and settlements in Missouri. Less than 1% of the 5,570 Missouri medical malpractice claims closed from 1993 to 1995 (35), resulted in payments of $1,000,000 or more.[9] That is consistent with national figures indicating that less than 1% of the verdicts in plaintiffs' favor were for more than $1,000,000.[10] After an extensive review of jury awards in medical malpractice cases, Neil Vidmar, Professor of Social Science and Law at Duke University, writing in the *Duke Law Journal*, declared, "The reputation of juries for reaching into the perceived deep pockets of health care providers and giving excessive awards for pain and suffering is not warranted."[11]

Few medical malpractice claims result in jury trials. For the years 1994 and 1995, a total of 161 medical malpractice cases were tried to jury conclusion in Missouri (4% of the total claims closed). Most cases are concluded by compromise settlement made with the authority and approval of the health care professionals involved. In cases which culminate in jury trial, defendant health care providers most frequently prevail. Missouri statistics for 1993 to 1995 indicate a 77% win rate for malpractice defendants statewide (204 of 264)[12] and a 68% win rate for cases tried in St. Louis County and City (55 of 81).[13]

Missouri Department of Insurance statistics demonstrate that the loss ratio for Missouri medical malpractice insurance companies declined from 97.8% in 1986[14] to 50.5% in 1995.[15] Medical malpractice insurers pocketed $60.5 million of the $122.2 million in premiums earned in 1995.[16] The Department of Insurance reports that medical malpractice insurance in Missouri is now more profitable than property and casualty insurance.[17]

Nationally, medical malpractice insurance is the most profitable line of insurance. The National Association of Insurance Commissioners' *Report on Profitability by Line, by State* (December 1992) found that medical malpractice insurance companies earned a $1.42 billion profit in 1991.[18] Indeed, the NAIC found that medical malpractice insurance has the highest profit measured as a percentage of premiums at 29.2%, with the next highest percentage being 15.6% for other liability lines.[19]

These statistical trends comport completely with the experiences of Missouri lawyers who represent plaintiffs in medical malpractice cases. Fewer malpractice claims are being made. Fewer malpractice lawsuits are being filed. When a case is filed, it tends to be one involving catastrophic injury. The reasons are largely economic.

Medical malpractice actions are invariably more expensive to bring to trial than other types of cases. Minimum expense is estimated at $25,000 on a malpractice case. Frequently, expenses exceed $100,000. The first issue addressed in the first client interview is whether the severity of the injury suffered as a result of the alleged negligence is sufficient to justify the expense of a malpractice action. Unless the injury is death, brain damage, major paralysis, or total disability of a wage earner from resuming gainful employment, further inquiry is seldom warranted. In medical negligence actions, as in most other common law actions, neither attorneys' fees nor most costs of suit are recoverable. The primary reason malpractice cases are so expensive is that expert witnesses are required and are expensive when found. The *New England Journal of Medicine* correctly noted, "Trial lawyers usually accept only the relatively few cases that have a high probability of resulting in a judgment of negligence with an award large enough to defray the high cost of litigation."[20]

Many malpractice complainants seek legal advice because a subsequent treating physician or health care professional suggested to them that they had been negligently treated. Subsequent treaters are seldom willing to put these opinions in writing, and when consulted by the patient's lawyer, are generally unwilling to testify against the former physician. Professional services are available to locate experts willing to "get involved." Typically the fees these experts command for record review, consultation, deposition, and one day attendance at trial range from $25,000 to $50,000.

Approximately 90% of the malpractice complainants are rejected after the first interview. Frequently, these outright rejections relate to the lack of merit to the claim of medical negligence. But, just as frequently, complaints which demonstrate a prima facie indication of merit are rejected because the injuries alleged are of insufficient consequence to justify the expense of further inquiry.

Files are opened on approximately 10% of cases which pass the initial litmus test screening for both sufficient injury and prima facie merit. In those cases, all available medical records and other data are assembled. All of the available information is submitted to consultants for their screening opinion. If that opinion comes back positive for both negligence and proximate causation of injury, a search is initiated for appropriate experts to act as trial witnesses. When such experts are located and confirmation of initial opinions is made, a claim is formally filed. The number of filings amounts to approximately one of every 50 complainants who first walk in the door with a complaint of medical negligence.

National research substantiates only a small number of victims of medical negligence file claims. A study published in the *New England Journal of Medicine* in July 1991 found that 98% of all adverse events due to negligence did not result in malpractice claims.[21] A Harvard Medical Malpractice Study estimated that only one in eight negligently injured patients ever brings a claim.[22]

These studies confirm findings dating back to the mid-1970s. An investigation into claims made against twenty-three California hospitals from 1975 and 1978 found that one in every 126 patients suffered injury due to negligence, but only 10% of them filed a claim.[23]

Non-meritorious cases have no business in our courts. Missouri malpractice law has provided a method for the elimination of frivolous lawsuits. An affidavit must be filed by the plaintiff certifying that a health care provider has reviewed the facts of the case and the case is meritorious.[24] This affidavit must be filed early in the case (within 90 days of filing suit).[25] Statistics show that, in 1995, 53% of all closed malpractice claims were closed because they were abandoned by the claimants.[26] This is an indication that the affidavit requirement is "weeding out" these non-meritorious cases. Of the cases that were not abandoned, the plaintiffs prevailed (by reason of settlement or verdict) in nearly 70% of the cases.[27]

The arguments advanced in the 1980s for malpractice reform have ceased to be viable. However, the myth of a multitude of frivolous lawsuits and a "billion-dollar-a-year" crisis continues to be propagated. One recurring element in the campaign to change the malpractice liability system is the concept of "defensive medicine."

The cost of defensive medicine is impossible to accurately estimate. The allegation that defensive medicine costs consumers billions of dollars annually is highly suspect. The billion dollar figure comes from surveys conducted by the AMA. The surveys asked physicians to estimate how much of the diagnostic testing they prescribed was "defensive." In 1992, the Congressional Budget Office declared, "Much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about malpractice."[28] That report was bolstered by a study (July 1994) by Congress. Congress' Office of Technology Assessment (OTA) found that, "overall, a small percentage of diagnostic procedures–certainly less than 8%–is likely to be caused primarily by conscious concern about malpractice liability." [29] The OTA also concluded that doctors who answered surveys about defensive medicine overestimated the rate at which defensive medicine is consciously practiced in diagnostic situations.[30]

Defensive medicine may to a large extent be good medicine. The AMA, as early as 1974, concluded,

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"It appears that 'defensive medicine' is essentially beneficial for patients."[31] Two doctors, writing on defensive medicine, have stated, "Standards in most specialties of medicine have not been clearly described, so that what might appear to be defensive medical practice to one clinician may, to another, be quality medical care."[32]

Proponents of malpractice reform continue to press for the elimination of patient's rights. Two areas are often mentioned as targets of further legislation: the collateral source rule and punitive damages.

The collateral source rule helps the injured victim of tortious conduct keep any health and disability benefits paid for by the victim's own insurance coverage in addition to the compensation received from the wrongdoer. Contrary to the assertion that the collateral source rule provides a windfall to the injured victim, abolition of the rule would create a windfall for the wrongdoer. A negligent health care provider should not be relieved from paying all of the damages he or she has caused because the injured person has the foresight to purchase health insurance benefits.

In reality, very few plaintiffs receive any form of "double recovery." More and more health insurance companies require reimbursement when the plaintiff receives a settlement or verdict.

Punitive damage awards in medical malpractice cases are extremely rare. There are two clear examples of the rarity of such awards. First, a review of the entire body of Missouri case law reveals only three medical malpractice cases in which punitive damage awards against health care providers were upheld on appeal.[33] Second, a Tort Victim's Compensation Fund was established by the Missouri legislature in 1987.[34] The law provides that one-half of any punitive damage judgment (in all types of cases, not only medical malpractice cases) in a Missouri state court, after deduction of attorney's fees and costs, must be paid into the Fund. After 10 years in existence, the Fund, as of May 1997, had a balance of $44,329.73. No money has been withdrawn from the Fund.

Missouri law provides that an award of punitive damages can be made only upon a showing of willful, wanton or malicious misconduct. Recently, the Missouri Supreme Court held that the high standard of "clear and convincing" evidence is needed before punitive damages can be considered.[35] Even in the very few cases where punitive damages are awarded, trial and appellate judges can, and often do, reduce the amounts awarded by the jury.

Punitive damages, while rare, serve an important role in deterring all individuals, including health care providers, from reckless and unconscionable behavior. Nationally, as well as in Missouri, many cases where punitive damages are alleged in malpractice lawsuits involve flagrant intentional misconduct such as sexual battery.

The freedom to file civil suits to seek economic redress is a precious right we enjoy as Americans. It is a right shared by health care providers and health care consumers alike. A review of new suits filed in the Circuit Courts of the City and County of St. Louis shows that many more civil suits are filed each year by physicians and hospitals to collect unpaid bills than are filed by patients for alleged medical malpractice.

Medical consumers in this country are fortunate to be afforded treatment by highly trained and skilled health care professionals. Malpractice claims are not made often given the magnitude of the health care industry. Competent, unbiased research suggests that medical consumers are not overly litigious and generally do not pursue spurious claims. These studies and the experience of plaintiffs' malpractice attorneys show that the principal cause of medical malpractice litigation is medical malpractice.

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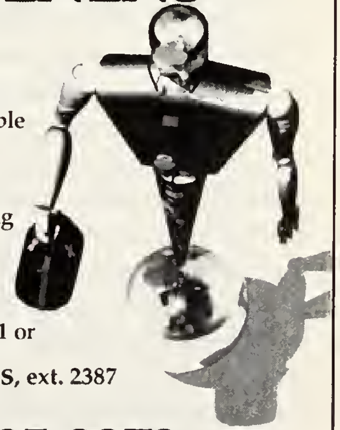

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Tobacco Use Among Missouri High School Students, 1995

Nancy Miller, MEd, CHES; Theophile Murayi, PhD; Eduardo J. Simoes, MD

Background

Tobacco use is the single leading preventable cause of death in the United States, killing more than 420,000 Americans each year.[1] As a result of intensive public health efforts, smoking rates among adults have declined over the past 30 years.[2] Cigarette smoking among adolescents also declined between 1974 and 1990.[3] However, according to the Centers for Disease Control and Prevention (CDC), smoking rates among high school students rose 26% from 1991 to 1995.[4] The 1994 Surgeon General's Report, *Preventing Tobacco Use Among Young People,* estimates that approximately three million adolescents currently smoke, with an additional one million young people becoming regular smokers each year.[5] The purpose of this paper is to compare the prevalence of various tobacco-use behaviors among Missouri high school students to those of high school students nationally, through an analysis of data from the 1995 Youth Risk Behavior Survey (YRBS).

The YRBS is a biennial stratified cluster survey of high school students that monitors six categories of health-related behaviors. These include behaviors contributing to unintentional and intentional injuries, tobacco use, alcohol and other drug use, sexual activity, diet and nutrition, and physical activity. The YRBS also helps monitor progress in achieving relevant national health objectives and national education goals. The Missouri Department of Elementary and Secondary Education (DESE) administered its first statewide YRBS in cooperation with the CDC. All surveys were conducted from February through May of 1995.

Methods

Sample Population

The sample was randomly chosen. Schools were selected with a probability proportional to school enrollment size. Twenty-nine schools were originally chosen, with 23 participating (79%). Within each participating school, intact classes of a subject required of all students or a period of the day in which all students were required to be present was randomly selected. All students in the selected classes were eligible to participate. The procedure ensured that each student had the same probability of selection for the sample.

From the original sample of 6,134 Missouri high school students, we analyzed data on 4,940 students (80%), after excluding the remainder for missing or inappropriate values on sociodemographic characteristics. The 1995 national school-based YRBS survey had a representative sample of 10,904 students. Demographic characteristics of the sample appear in Table 1.

Statistical Analysis

Because of the complex survey design, Software for the Statistical Analysis of Correlated Data (SUDAAN) was used to calculate prevalence estimates and 95% confidence intervals by age, grade level, gender, and racial/ethnic characteristics for nine tobacco-use behaviors.[6] This included information on students who are currently smoking, smoke frequently, use chewing tobacco, had ever smoked in their lifetime, and the age when students first smoked an entire cigarette.

Information on students' use of cigarettes and smokeless tobacco products on school property, how tobacco products are acquired, and whether or not they were asked for proof-of-age when purchasing tobacco was also studied. Data was weighted to compensate for unequal probability of sample selection and to diminish bias due to under-representation in the sample. Results were tabulated with similar estimates nationwide to

Table 1. Demographic Characteristics of the Sample--Missouri.

Sample Size **N= 4,940**
The school response rate was 79% and the student response rate was 80%. The overall response rate was 79 x 80 = 63%.

Age	**N**	**%**	**95% CI^**
12-15 years	1,770	42.2	(+/-1.7)
16-17 years	2,434	57.9	(+/-1.7)
Total	4,204	100.0	
Gender	**N**	**%**	**95%CI^**
Female	2,439	49.1	(+/-1.5)
Male	2,447	50.9	(+/-1.5)
Total	4,886	100.0	
Race/Ethnicity	**N**	**%**	**95%CI^**
White	4,102	87.4	(+/-1.0)
African-American	395	6.2	(+/-0.7)
Hispanic	96	1.8	(+/-0.4)
Other	261	4.6	(+/-0.6)
Total	4,854	100.0	
Grade in school	**N**	**%**	**95%CI^**
9	1,430	29.3	(+/-1.4)
10	1,344	26.3	(+/-1.4)
11	1,167	23.2	(+/-1.3)
12	925	21.2	(+/-1.3)
Total	**4,866**	**100.0**	

^ 95% Confidence Interval

determine differences. YRBS national data for 1995 was obtained from the CDC.[7]

Results

Current and Frequent Smoking

Current cigarette smoking, defined as smoking within the last 30 days, is significantly higher among Missouri high school students than for the United States, 39.8% vs. 34.8% respectively. This differential is even greater if we compare Missouri ninth graders and all Missouri high school males to similar students nationally, 39.9% vs. 31.2% and 40.2% vs. 35.4% respectively (Table 2). Missouri's racial/ethnic groups have higher smoking rates than United States racial/ethnic groups, and white and Hispanic rates are higher than those for African-Americans in both Missouri and the United States. Other differences are seen in the smoking rate by grade. In the United States, the current smoking rate peaks among twelfth graders at 38.2%, while Missouri's peaks in ninth (39.9%) eleventh grade (41.8%) and twelfth grade (40.2%).

For frequent smoking, substantially more of Missouri youth (20.9%) smoked 20 or more days in the month preceding the survey, compared to 16.1% in the United States. Rates for frequent smoking among Missouri males, 21.3%, also exceeded those of the nation at 16.3%. Missouri's ninth graders (19.1%) are more than twice as likely to be frequent smokers as ninth graders nationally (9.6%), with tenth graders at 19.9% for Missouri vs. 13.3% for the United States. Racial/ethnic differences show that Missouri's white youth have frequent smoking rates 2.3 times greater than the Missouri African-American youth, while among Hispanic youth the rate is 2.8 times more than for Missouri African-American youth. This differs from United States rates where white youths have a frequent smoking rate more than four times higher than African-Americans, with Hispanics at nearly twice as much as African-Americans. Frequent smoking among Missouri's African-American females is five times greater than nationally at 6.8% vs. 1.3%. Missouri's Hispanic youth have frequent smoking rates nearly 2.6 times those nationally, 25.9% vs. 10%. Frequent smoking increases by grade level, from 19.1% among Missouri ninth graders vs. 9.6% United States, to 22.6% among Missouri twelfth

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graders vs. 20.9% for the United States. These findings imply that much of the differential in frequent smoking between Missouri and the United States may be attributable to age, gender, and racial/ethnic differences.

Smokeless Tobacco Use

Overall chewing-tobacco rates are substantially higher in Missouri as well, with 16% of youth using these products, compared to 11.4% for the United States. The differences in smokeless tobacco use between Missouri and the United States is evident across all sub-groups defined by age, gender, race/ethnicity, and grade in school. Among Missouri males, these prevalences exceed the 95% confidence intervals compared to the United States, 28.7% vs. 19.7% respectively. Missouri's Hispanic students' rates of smokeless tobacco were about five times more than similar students nationally. The Hispanic rate of smokeless tobacco use (20.2%) exceeds that of whites (16.6%) as well as African-Americans (5.1%) (Table 2). Smokeless tobacco use among Missouri's ninth, tenth and eleventh graders is 15.5%, 15.5%, and 18.7% versus 11.2%, 9.6%, and 13.0% for the United States.

Early Use of Cigarettes

Missouri high school students' rate of having tried cigarette smoking, even if it is only one or two puffs, 75% (+/-1.3), exceeds that for the United States at 71.3% (+/-1.6) (Table 3). Age and race are factors more likely to explain the differences, as Missouri high school white (74.6%), African-American (76.6%), and ninth grade (73.2%) rates for lifetime use are also above those nationally (71.1%, 66%, and 63.4%) by a significant amount.

In Missouri, 32.2% of high school students smoked a whole cigarette before age 13 as compared to 24.9% of high school students nationally. Among Missouri males, the rate was 37.5% versus 27.8% for the United States. The Missouri male rate also significantly exceeded that for Missouri females. White youth (32.7%) and ninth graders (38.5%)

Table 2. Percentage of high school students who used cigarettes or smokeless tobacco by sex, race/ethnicity, and grade--Missouri, Youth Risk Behavior Survey, 1995.

	Cigarette Use				**Smokeless**	
	Current^		**Frequent^^**		**Tobacco Use+**	
Category	**%**	**(95%CI*)**	**%**	**(95 %CI*)**	**%**	**(95 %CI*)**
	N = 4,714		N = 4,714		N = 4,837	
Gender						
Female	39.4	(+/-2.2)	20.5	(+/-1.8)	2.8	(+/-0.8)
Male	40.2	(+/-2.2)++	21.3	(+/-1.9)++	28.7	(+/-2.0)++
Race/Ethnicity**						
White	40.7	(+/-1.7)	21.4	(+/-1.4)	16.6	(+/-1.3)
Female	41.1	(+/-2.4)	21.5	(+/-2.0)	2.8	(+/-0.9)
Male	40.4	(+/-2.4)	21.3	(+/-2.0)	30.1	(+/-2.2)
Afro-American	23.9	(+/-5.4)	9.4	(+/-3.8)	5.1	(+/-3.1)
Female	16.8	(+/-5.5)	6.8	(+/-3.8)++	1.3	(+/-1.8)
Male	32.2	(+/-9.3)	12.5	(+/-6.9)	9.1	(+/-5.9)
Hispanic	41.4	(+/-12.0)	25.9	(+/-11.0)++	20.2	(+/-9.2)++
Female	34.2	(+/-17.0)	18.8	(+/-13.0)	2.5	(+/-4.9)
Male	45.3	(+/-15.0)	29.8	(+/-15.0)	29.6	(+/-13.0)
Grade						
9	39.9	(+/-2.9)++	19.1	(+/-2.4)++	15.5	(+/-2.2)++
10	37.6	(+/-2.9)	19.9	(+/-2.5) ++	15.5	(+/-2.2)++
11	41.8	(+/-3.2)	22.4	(+/-2.7)	18.7	(+/-2.6)++
12	40.2	(+/-3.6)	22.6	(+/-3.1)	14.1	(+/-2.5)
Total	**39.8**	**(+/-1.6)++**	**20.9**	**(+/-1.3)++**	**16.0**	**(+/-1.2)++**

^ Smoked cigarettes on >1 of the 30 days preceding the survey.
^^ Smoked cigarettes on >20 of the 30 days preceding the survey.
+ Smokeless Tobacco use on >1 of the 30 days preceding the survey.
* 95% Confidence Interval.
** Numbers for other racial/ethnic groups were too small for meaningful analysis.
++ 95% Confidence Intervals of MO and US do not overlap.

in Missouri smoked their first cigarette earlier than students nationally at 25.9% and 28.1% respectively.

Tobacco Use on School Property

A substantial number of Missouri students (9.5%) used smokeless tobacco products on school property on one or more of the 30 days preceding the survey, compared to 6.3% of students nationally (Table 3). Missouri male, Hispanic, and eleventh and twelfth grade students' rates of smokeless tobacco use on school property is significantly higher than that for the United States. Although among United States students, whites are more likely to use smokeless tobacco at school than any other racial/ethnic group, in Missouri, the Hispanic rate exceeds that for Whites and African-Americans. Missouri students' use of smokeless tobacco products at school ranges from 4.6% of students using it one to two days a month to 4.7% of students using it daily. At least 16% of Missouri students used cigarettes on school property on one or more of the 30 days preceding the survey. This is the same as the national rate. Of Missouri students, 3.5% smoked

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Table 3. Percentage Distribution of Lifetime Use of Cigarettes, Smoking of a Whole Cigarette before age 13, Cigarette Use and Smokeless Tobacco Use on School Property, During the 30 Days Preceding the Survey Among High School Students by Gender, Race/Ethnicity, and Grade--Missouri, 1995 Youth Risk Behavior Survey.

Category	Lifetime Cigarette Use %	(95%CI**)	Smoked Whole Cigarette before age 13 %	(95%CI**)	Cigarette Use School Property* %	(95%CI**)	Smokeless Use On School Property* %	(95%CI**)
	N = 4,776		N = 4,818		N = 4,821		N = 4,839	
Gender								
Female	74.6	(+/-1.9)	26.7	(+/ -2.0)	13.9	(+/- 1.5)	0.8	(+/-0.4)
Male	75.4	(+/-1.9)	37.5	(+/- 2.2)++	18.1	(+/- 1.8)	17.9	(+/-1.8)++
Race/Ethnicity*								
White	74.6	(+/-1.5)++	32.7	(+/- 1.6)++	16.1	(+/- 1.3)	9.7	(+/- 1.0)
Female	74.3	(+/-2.0)	27.2	(+/- 2.2)	14.2	(+/- 1.7)	0.6	(+/- 0.4)
Male	74.9	(+/-2.1)	38.3	(+/- 2.4)	18.0	(+/- 1.9)	18.6	(+/- 1.9)
Afro. American	76.6	(+/-4.8)++	19.4	(+/- 4.3)	7.3	(+/- 3.4)	3.9	(+/- 3.0)
Female	76.5	(+/-6.8)	17.2	(+/- 5.8)	3.8	(+/- 2.9)	0.6	(+/- 1.1)
Male	76.7	(+/-6.8)	21.8	(+/- 6.4)	11.2	(+/- 6.3)	7.4	(+/- 5.8)
Hispanic	83.3	(+/-7.5)	36.8	(+/-11.0)	21.9	(+/- 9.2)	6.9	(+/- 8.7)++
Female	80.8	(+/-13.0)	20.6	(+/-14.0)	14.4	(+/-11.0)	2.5	(+/- 4.9)
Male	84.7	(+/-9.1)	45.5	(+/-15.0)	25.9	(+/-13.0)	24.6	(+/-13.0)
Grade								
9	73.2	(+/-2.5)++	38.5	(+/- 2.9)++	17.5	(+/- 2.2)	8.4	(+/- 1.7)
10	73.5	(+/-2.6)	32.5	(+/- 2.8)	15.2	(+/- 2.2)	8.6	(+/- 1.7)
11	77.6	(+/-2.6)	29.0	(+/- 2.9)	15.9	(+/- 2.4)	11.4	(+/- 2.1)++
12	76.4	(+/-2.9)	26.1	(+/- 3.2)	15.1	(+/- 2.7)	9.7	(+/- 2.2)++
Total	**75.0**	**(+/-1.3)++**	**32.2**	**(+/- 1.5)++**	**16.0**	**(+/-1.2)**	**9.5**	**(+/-1.0)++**

* On >1 of the 30 days preceding the survey.
** 95% Confidence Interval.
*** Number of other racial/ethnic groups were too small for meaningful analysis.
++ 95% Confidence Intervals of MO and US do not overlap.

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cigarettes on school property one or two days during the month preceding the survey, while 4.8% report doing so on all 30 days.

Cigarette Acquisition

More of Missouri's twelfth graders, 70.9%, purchased cigarettes in a store or gas station (Table 4), compared to the United States rate of 50.4%. Students who smoked 20 or more days a month were more apt to purchase cigarettes from a store (60.5%) than students who smoked only one to five days a month, who used borrowing (60.7%) as their primary method of obtaining cigarettes.

When purchasing cigarettes, more of Missouri high school students (26.9%) were asked to show proof-of-age as compared to those nationally (22.5%). White students (68.2%) and twelfth graders (56.7%) in Missouri had a lower prevalence of not being asked for proof-of-age, as compared to the United States rates of 76.5% and 77.9%. Interestingly, significantly more twelfth graders in Missouri were asked for proof-of-age when purchasing cigarettes than were Missouri students in grades 9-11.

Table 4. Percentage Cigarette Purchase from a Store and Minors not Asked for Proof of Age When Buying Cigarettes in a Store, Among High School Students Ages <= 17 who Currently Smoke Cigarettes, by Gender, Race/Ethnicity, Grade--Missouri, 1995 Youth Risk Behavior Survey.

Category	Bought in a Store (^,^^) %	(95%CI*)	Not Asked to Show Proof of Age When Buying Cigarettes (^^) %	(95%CI*)
	N = 1,655		N = 983	
Gender				
Female	35.8	(+/- 3.6)	79.3%	(+/- 4.1)
Male	42.5	(+/- 3.8)	68.3%	(+/- 4.5)
Race/Ethnicity**				
White	45.1	(+/- 2.6)	68.2	(+/- 3.1)++
Female	41.8	(+/- 3.7)	72.9	(+/- 4.3)
Male	48.3	(+/- 3.8)	64.1	(+/- 4.4)
Afro-American	27.6	(+/- 11.0)	65.6	(+/- 14.0)
Female	28.1	(+/- 16.0)	78.2	(+/- 15.0)
Male	27.4	(+/- 13.0)	57.9	(+/- 14.0)
Hispanic	48.3	(+/- 18.0)	67.9	(+/- 18.0)
Female	80.7	(+/- 1.4)	85.5	(+/- 19.0)
Male	37.1	(+/- 2.7)	61.1	(+/- 3.7)
Grade				
9	22.9	(+/- 3.9)	70.1	(+/- 6.5)
10	40.1	(+/- 4.8)	73.9	(+/- 5.4)
11	52.3	(+/- 5.0)	74.1	(+/- 5.1)
12	70.9	(+/- 5.1)++	56.7	(+/- 5.9)++
Total	39.1	(+/- 2.6)	73.1	(+/- 3.1)

^ Convenience store, supermarket, or gas station.
^^ Among students who ever bought cigarettes in a store during the 30 days preceding the survey.
* 95% Confidence Interval.
** Number of other racial/ethnic groups were too small for meaningful analysis.
++ 95% Confidence Intervals of MO and US do not overlap.

Summary

The findings in this report show that Missouri's high school student tobacco-use prevalence rates substantially exceed those of the nation in eight of the nine tobacco use areas: students who ever smoked, age when first smoked, current smoking status, cigarette-smoking frequency, chewing-tobacco use, acquisition of tobacco, if asked for proof-of-age, and use of smokeless tobacco products on school property. Only the category of using cigarettes on school property had comparable prevalences with national data.

Among the respondents, 75% reported that they had tried smoking, even one or two puffs, during their lifetime. Approximately 40% of Missouri students had smoked cigarettes during the 30 days preceding the survey (current smokers), with 21% smoking on more than 20 of the previous 30 days (frequent smokers.) Sixteen percent of Missouri youth use smokeless tobacco products. Students acquired tobacco products from a variety of sources, including direct purchase and borrowing tobacco from another person. About 27% of Missouri students report being asked to show proof-of-age when purchasing tobacco products. Students use tobacco products on school grounds in spite of laws and policies prohibiting such use. Sixteen percent of students report smoking cigarettes, and 9.5% use smokeless tobacco products at school. Missouri's rates for smoking among youth compared to states nationally include the second highest for current smoking, third highest for frequent smoking, and fifth highest for smokeless tobacco use.

Discussion

The students participating in the 1995 Missouri YRBS survey were more likely to be white (87.4% MO vs. 67.2% US) and in ninth grade (29.2% MO vs. 22.9% US). According to the 1994 Surgeon General Report on Smoking, *Preventing Tobacco Use among Young People*, African-American youths typically have lower smoking rates. African-Americans represent a smaller fraction of the Missouri population. However, the proportion of Missouri's African-American youth participating in the survey (6.1%) was far less than their average attendance in high school at 14.5%.[8]

Studies by Johnston, O'Malley and Bachman (1994), show that children and adolescents are beginning to smoke at earlier ages with most having smoked their first cigarette before age 13.[9] Our findings are consistent with this research. Early initiation of cigarette smoking has also been associated with a greater potential for heavy daily consumption, longer duration of smoking, and nicotine dependence.[10]

Missouri's adult (>age 18) smoking rate, 24.3%, is higher than the United States average of 22.4%.[11] Missouri's rate of smoking among persons age 18-30 (26.9%) also exceeds the national average. Some studies show that children of smokers may be more apt to become smokers themselves.[12] Pierce and Gilpin (1996) estimate that teenagers who become smokers today are likely to continue smoking for a period of 16 years for males and 20 years for females.[13]

Projections from the CDC (1996) indicate that if current patterns of smoking behavior persist, an estimated five million United States persons who were age 0-17 years in 1995 could die prematurely from smoking-related illnesses, resulting in $200 billion (in 1993 dollars) in future health-care costs, and approximately 64 million years of potential life lost.[14] Considering the findings in this study, it is likely that Missouri's smoking rates among adults will not be decreasing in coming years. As a result, Missouri's smoking-attributable morbidity, mortality, and economic costs may continue to climb as well.

One way to reduce the prevalence of tobacco use among minors is by reducing sales to them. This can be done by implementing and enforcing strong state and local laws prohibiting sales to minors, reducing advertising of tobacco products that are targeted to youth, requiring proof-of-age when selling tobacco products, conducting random compliance checks, and fining merchants who sell tobacco to minors, as well as raising prices through substantial increases in tobacco excise taxes.[15] MoMed

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Disease Management as Part of a Population-Based Approach to Physician Directed Medical Care

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Health care is reorganizing for several reasons. The consolidation of health care is being driven by medical inflation concerns, an aging population, technical advances and their opportunities, quality issues such as consolidation of acute inpatient services, and more emphasis on outpatient services. Many of these areas are influenced by the economics of health care, including managing cost and prepaid services. The traditional physician-patient based approach to medicine is evolving into the management of a population's risk, demand, disease, and outcomes. Missouri physicians keep hearing about population-based medicine, disease management, and outcomes measurements and may find some of these concepts new to their daily practice. Many feel these are concepts for east and west coast physicians where managed care is much more mature. While that may be true for some areas of the state, the physicians who have begun and who begin now to develop an infrastructure to introduce, build, support, and implement these new patient management programs will have the advantage. Government and business will demand population-based patient management programs as a prerequisite for participation with their employees and retirees. This foundation cannot be poured overnight. Preparing now for this future shift in medical care is a must.

Disease management is one of several population- based approaches to medical care currently being developed by managed care participants and pharmaceutical companies. This is a new strategy to control medical costs. It provides a more efficient means of treatment than the acute care management of complications we often saw in earlier fee-for-service medicine. Disease management is a new process and requires change in our practice. We should recognize this new strategy as easily implemented into the new evolving, population-based delivery models of medicine.

Table 1. Chronic illnesses often used in disease management protocols

- Cancer
- Acute Otitis Media
- Diabetes
- Hyperlipidemia
- Asthma
- Hypertension
- COPD
- Hormone Replacement Therapy
- AIDS
- Stroke

As physicians seek better ways to provide quality care for their patients under the cost pressures that are apparent to us all, they look to redesigning their care delivery. The historical clinical model of medicine, although individualistic and physician/patient focused, had the flaw of causing many individual decisions in patient treatment, thus forcing a fragmented delivery system. Good quality medicine in a fragmented delivery system is not affordable to business and government payors. Thus physicians were forced to design and develop a new, less fragmented, less acute care-focused, more disease continuum-based approach. These new approaches are often referred to as "population-based" medicine, which include predisease, outpatient care, inpatient care, and the coordination of this continuum.

Although based in the traditional epidemiologic and public health principles of medicine, the evolving population-based approach to clinical practice is not the same as public health. An important operational difference stems from the two different economic incentives facing payors and public health authorities. Health insurance is designed to deal with the illness episodes of only the part of the population which it serves. It does not usually cover the social or hygienic needs of a population as classic public health programs do. Traditional public health programs which also affect the health of the population, including sanitation and programs which reduce future morbidity (i.e. decreasing cholesterol levels), are not attractive to private insurance payors. A new model of "population-based" medicine understands the health care needs of a certain population are known, and programs to decrease both the short-term and long-term costs of medical care received by that population need to be designed. Properly designed programs should be more efficient than similar efforts which depend upon numerous steps taken during countless physician/patient interactions. Disease management strategies are designed to help implement population-based medical models.

Commercial disease management strategies are based in well known observations that small portions of the population often use most of the health care resources, and that increasing short-term costs in these areas may produce larger long-term savings in total. Disease management of targeted populations is able to manage the total cost of care for that population segment, usually by preventing complications or recognizing early complications of chronic disease. This decreases the overall population costs and improves the quality of care, again by preventing or limiting complications of these chronic diseases. Potential interventions may range from patient focused efforts such as education for chronic obstructive pulmonary disease, to multifactorial interventions such as educational, pharmaceutical, and behavioral modification techniques for asthma patients, to specialized treatment facilities for stroke patients. Not all of these interventions require daily, direct physician/patient intervention, but they do demand physician participation in their development, design, implementation, and ongoing management.

Table 2. Elements of Disease Management Programs

- Formulary Modifications
- Educational Interventions
- Outcomes Assessments
- Modeling Treatment Options
- Unique Treatment Options
- Pitfalls and Promises

The problem, thus the opportunity, is that commercial, population-based medicine suffers from the same economic forces which are trying to create it. The short term profit/cost syndrome must be overcome for physicians to break through this new paradigm of health care. Using the disease management ideas in this article and the outcomes measurement ideas in the following article, physicians can examine the pitfalls and promises of this evolving population-based, medical care process.

Elements of a Disease Management Program

Formulary Modifications

Formulary modifications frequently occur when disease management programs are initiated. They are usually an extension of disease treatment guidelines. These guidelines should be developed from formularies that lead to overall health system cost savings, not from unit drug acquisition costs. Programs often consist of a closed formulary to promote high quality and low cost products within the system. Pharmacoeconomic analyses of disease states are often useful in developing the formulary.

Education Interventions

Depending upon the diseases selected for management, educational efforts may be aimed primarily at physician prescribers, or at both physician prescribers and patients. For example, acute infectious disease treatment guidelines should be directed at physicians only, where as chronic diseases such as diabetes, asthma, hormone replacement therapy, hypertension,

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and others are important to have both physician direction and patient education for optimal compliance.

Outcomes Assessments

Generally divided into clinical, economic and humanistic (quality of life, patient satisfaction) categories, outcomes assessments are frequently ignored as important tools in disease management success. Baseline data, as well as future data, are important when measuring the effectiveness of treatment guidelines and deciding on modifications of the protocols. The objective of physician integrated care is not only to lower costs, but to achieve measurable quality improvements, a task not able to be completed without baseline data and outcomes assessments. While often difficult to measure, the intangibles of quality of life and patient satisfaction are just as important to patients as the tangible clinical and economic successes we often focus on.

ModelingTreatment Options

Modeling is a basic tool of microeconomics, and it is beginning to be used by physicians. Modeling describes relationships between inputs and outcomes. To be useful, models must simplify and abstract data elements within disease management. Models may be useful in making predictions, drawing conclusions or simplifying complex data elements. One example of a model is a decision tree or algorithm, techniques we as physicians often use subconsciously in diagnosing and treating patients. When we consolidate these thoughts onto paper, we call them practice protocols or clinical pathways. Extrapolating these techniques into disease management programs may not be as foreign as we may perceive.

Unique Financial Arrangements

Disease management programs may involve global capitation for total health care costs, modified arrangements for groupings of diseases or specific specialty carve outs for certain disease states. It is important, during the negotiating phase of this contract process, to identify and define exactly which services and diseases will be included and excluded from the program, as to determine a fair financial compensation for managing the program. Optimal contract length, types of internal and external education efforts to insure compliance, and data management systems are also important to coordinate.

Pitfalls

Due to its attractiveness as a cost reducing strategy and its potential for broad application, disease management is a popular topic in health care. High profile pharmaceutical and home care companies are very involved and investing in these programs. Although physicians may worry about a loss of control in patient care, many of these established, well run disease management programs on the east and west coasts deliver improved outcomes and decreased costs using programs to manage chronic diseases. That being said, there are several potential pitfalls to disease management which physicians should be aware of:

❶ Who is administrating or promoting the disease management program? Some pharmaceutical companies often make a credible argument that more compliance with a drug regimen is always better than less compliance, however, many widely used drug regimens are based on the original FDA approval studies or on existing practice patterns that may not be currently optimal. Longer or more expensive drug treatment regimens for certain conditions may not be better than shorter, less expensive approaches (i.e. otitis media, infectious endocarditis prophylaxis for mitral valve prolapse, six versus nine month tapering periods for antiepileptic medications in children). As with many new programs, it is prudent for physicians to assure themselves of the efficacy and efficiency of these programs, not just to accept the sponsor's assertions without challenge.

❷ Certain disease management programs which are too effective and/or not duplicated in the community may give an actuarial disadvantage. Well administered, well advertised programs for AIDS, diabetes, asthma or other chronic diseases may lend themselves to an adverse population selection for your clinic. If this is or could be the case, and if physicians are under a capitated payment arrangement, additional financial consideration must be negotiated to take into account this sicker population.

❸ Some disease management programs may overestimate their benefits in certain populations. Prenatal programs in suburban populations where prenatal care compliance is already very good, may not be cost effective or address a problem for that community. Patient demographics should play a role in choosing which programs are to be instituted.

❹ Fragmentation of care is another potential pitfall. As programs become more successful, and specialists take advantage of carve outs in their areas, patients may again find themselves in a fragmented, "single episode of care" environment, without one physician able to look at the "entire patient" and coordinate care. Due to this fragmentation potential, and because multiple, specialty carve out programs are difficult to administer from an insurers perspective, specialty groups, specialty IPAs, etc., may have trouble accessing these patients. Specialists must be able to show unusual value and cost-effectiveness in their care. They must provide service for entire market regions, decrease their cost per episode of disease, and have the information technology to prove better outcomes and track savings over time. These specialty carve out groups will not include all specialists in the region, forcing a Darwinian consolidation of progressive specialists into a surviving new order. Only then will specialty carve out groups rival multispecialty groups for an advantage.

❺ There are currently many database deficiencies. We just do not have good historical, computerized information to serve as a baseline to measure improvement. This will become less of a problem in the future as measurement systems are developed and archived. The integration of physicians and the development of integrated health delivery systems to encourage and support these data collections will also help frame a baseline and benchmark for future study.

Promises

Population-based medicine, including disease management, is not a replacement, but rather an adjunct to physician-patient based medicine. The two work side by side delivering each their efficiencies and balancing each their inefficiencies in a new, evolving patient care network model. There are three long term promises of disease management.

❶ Disease management brings an opportunity to develop systems to solve health care problems. Using systems, rather than individual experiences and anecdotes, will enhance physician performance by decreasing unnecessary variability in diagnosis and treatment plans. A systems approach will allow physicians to lead and develop avenues for patient care that better integrate nurses, pharmacists, and other allied health professionals, paving the way for additional patient contact by health care providers to insure better compliance and earlier detection of costly complications. This new approach will lead to a higher quality of life for patients suffering from chronic diseases.

❷ Implementation of quantifiable, measurable programs will allow the collection of comparable data on patient populations. This will provide information on previous treatments and outcomes to allow for continuous improvement in present and future patient care.

❸ Disease management programs improve medical decision making by exposing physicians to the full ramifications of their previously fragmented decisions. By connecting preventive care, early diagnosis, management of the outpatient care of chronic illness, and assessment of the acute exacerbations or complications of chronic illnesses into a continuum which can be recognized, physicians will be able to assess and adjust to achieve the long term benefits, both cost and quality, of an integrated, physician managed, medical delivery system.

Conclusion

Businesses, government payors, and insurance companies are very interested in pursuing the efficiencies and advantages of population-based, medical care

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programs. The programs which can prove their benefit in the quality and cost aspects of maturing managed care markets will insure their presence in Missouri. While many of us are hoping to be part of these changes, more progressive health systems have already begun to make inroads in this area. Physicians are able to lead and manage these programs, but will only have that opportunity if we proactively seek out these opportunities. We need physician leaders to develop these programs, and physician followers to support these programs. Redefining independence and autonomy in this changing medical climate is preferable to abdicating our previous, highly regarded position. All physicians, be they leaders, followers or somewhere in-between, will need to embrace and support these changes to maintain their medical independence and autonomy. MoMed

The Author

Dr. McIntire is a partner with Boyce and Bynum Labs in Columbia, and a managed care consultant for the Jefferson City Medical Group.

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Outcomes Measurement as Part of a Population-Based Approach to Physician Directed Medical Care

Timothy McIntire, MD, MBA

In the previous Disease Management article, population-based medical care was discussed as a program which physicians could direct, if we understood the opportunities of our changing health care delivery system. Another component in a population-based system of medical care is outcomes measurement. No process can be managed to any benefit unless it can be measured. Information technology, providing physicians a current baseline and a method of measuring future performance, is the key to any successful program. Benchmarks may come and go with the different successes and failures of some programs, but measurements must always be as consistent and as minimally biased as possible.

Table 1. The development of an Outcomes Plan includes:

- Evaluation of the current delivery of care
- Identify specific interventions
- Development of a plan
- Generate data requirements
- Implementation of the plan
- Measure and evaluate the outcomes

Development

The development of an outcomes plan forms the foundation from which physicians can begin to gather data, measure indicators, and produce information (Table 1). This information will allow higher quality, lower cost care to be accessible to all patients. Diabetes is often used as an example of a reasonably prevalent chronic disease which is targeted in population-based case studies. An example of five steps in developing an outcomes measurement plan for a pilot diabetic population might be as follows.

❶ Evaluate the Current Delivery of Care. The use of patient demographics, clinical processes, and clinical outcomes are three starting points in the development of a plan.

Patient demographics may be used in identifying certain high risk areas in your patient base. Younger patients tend to be Type I diabetics and are at a higher risk for diabetic ketoacidosis hospitalizations, where as middle-aged patients who are diabetic are likely to suffer from Type II diabetes. These older patients will be better candidates for diet and exercise interventions. A third demographic group could be the elderly Type II diabetic patients who may be beginning to experience the long-term microvascular effects of diabetes.

Clinical processes are important in understanding if the care being provided is optimal. Are hemoglobin A1c's being done and correlated? Does the physical exam include inspecting the patient's feet at every office visit? How and how often is wound care education done? Are these results documented, measured, and compared to an acceptable benchmark? Good clinical processes usually lead to good clinical outcomes.

❷ Specify Interventions. After developing a baseline evaluation, deficiencies within the plan may be identified. The next step is to specify interventions which address these deficiencies. This important step should be revisited often in the measurement and outcomes assessment process.

❸ Develop a Plan. Based on the interventions identified and implemented, a plan is developed. This outcomes measurement plan should follow the

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clinical decisions developed to support a plan of patient care. The outcomes plan should specify the clinical, economic, and humanistic outcomes to be measured, how often the measurements should occur, and what data are necessary to perform the measurements (Table 2).

❹ Generate Data Requirements. Data requirements necessary to conduct analyses are assessed. These data requirements should be coordinated with the measurement plan to support the proper interaction between data and measurement. At times the necessary data may be difficult to obtain. For example, if the information needed can only be collected by personal review of the medical record, the cost of retrieving that data must be balanced with the value it provides.

❺ Implement and Measure. Implementation of a plan with concurrent and future measurements of outcomes provides feedback in assessing the value and effectiveness of treatments in chronic diseases.

Implementation

Outcomes measurement requires an understanding of the distinction between effectiveness and efficacy in population-based medical care. Treatments with proven efficacy do not always perform as well under the conditions of typical clinical practice (effectiveness). Efficacy studies are usually characterized by highly specialized physicians treating selected patients on tight protocols in a setting where both patients and physicians have economic incentives to comply. In contrast, effectiveness studies are treatments which are seen in the usual community-based practice setting. Most therapies require evaluation of efficacy before being implemented. But, documentation of efficacy in a controlled setting does not always extrapolate to success in the more usual practice settings where both patients and physicians face natural barriers to care. These effectiveness issues have a direct influence when assessing the relative cost-effectiveness of a drug or protocol in a community.

To address these problems, most effectiveness studies have been done as observational studies, as opposed to the more classic, randomly assigned efficacy studies. Selection bias, which may occur when patients are not randomly assigned to alternative treatments, becomes potentially problematic, and the adjustment for case mix and severity of illness becomes important.

Table 2. Examples of Outcomes Measurements

CLINICAL
- MEAN TESTS / PATIENT (i.e. HbA1c)
- MEAN TEST VALUE OVER TIME (i.e. HbA1c)
- MEAN HOSPITAL LENGTH of STAY (DAYS)
- MEAN NUMBER OF HOSPITALIZATIONS/ 1,000 COVERED LIVES
- MEAN NUMBER OF EMERGENCY DEPARTMENT ADMISSIONS

HUMANISTIC
- AM. UROLOGICAL ASSOC. SYMPTOM SCORE (SYMPTOMS)
- SF - 36 QUESTIONNAIRE (QUALITY of LIFE)
- KATZ DAILY LIVING ACTIVITY SCALE (FUNCTIONAL STATUS)
- GROUP HEALTH ASSOC. OF AM. SURVEY (PATIENT SATISFACTION)

ECONOMIC
- COST of HOSPITALIZATION, OUT PATIENT VISITS, EMERGENCY DEPARTMENT VISITS (DIRECT COSTS)
- WORK LOSS, RESTRICTED ACTIVITY DAYS (INDIRECT COSTS)

Prospective effectiveness trials are now beginning to emerge. These prospective trials, to overcome their inherent bias, enroll heterogeneous participants, use providers more similar to those who treat the disease, impose few protocol-driven interventions, and incorporate outcome measures relevant to the disease and delivery system. Physicians must try to balance the selection biases of these trials, while still addressing their outcomes and effectiveness.

Outcomes information assumes that a systematic measurement of outcomes and a review of the treatments that precede the outcomes will lead to optimal therapy. This process should allow for management recommendations, followed by reevaluation of outcomes and a continuous opportunity for improved delivery of care. This is a dynamic management system which seeks to define the range of outcomes produced by alternative interventions. Outcomes measurement strives to produce desirable results in a clinical setting, allowing for the application of these results to be of benefit in current clinical practice.

Outcomes information requires an infrastructure in which population-based outcomes can be readily assessed. First, a common set of outcomes measures should be endorsed and used. Second, the uniform collection and coding of outcomes data in the population are necessary, this process can be difficult when care is rendered across numerous providers who are not necessarily linked through computerized information systems. Finally, these data are to be linked to information helpful in changing the structure of health care as it was previously delivered.

The limited training and orientation of health care professionals to this type of analysis and program development adds to the difficulty in implementing outcomes measurements. Although simple in theory, incorporation of outcomes measurement principles into medical practice requires a complex, expensive set of processes become integrated into health care delivery. It also requires uniform collection of data and transmission, and consent from patients to provide and share the data.

In the future, physicians will provide improved patient health by maximizing functionality, minimizing disease, and improving the efficiency and cost effectiveness of health care. The use of outcomes tools, including linked databases and collaborative research efforts, will allow the role of outcomes measurement and management to mature in the application of the population-based medical care of the 21st century. MoMed

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Gamma Knife Radiosurgery:
Indications, Techniques, and Results in 200 Patients Treated at the Midwest Gamma Knife Center

Jonathan D. Chilton, MD, MPH

Abstract

During radiosurgery, a single high dose of ionizing radiation is delivered with exquisite precision to a radiographically defined intracranial target. More than 60,000 patients have been treated worldwide since the first Gamma Knife was installed in Stockholm in 1968. Indications include arteriovenous malformation, cerebral metastasis, acoustic neuroma, meningioma, malignant glioma, and trigeminal neuralgia. Two hundred patients have been treated at the Midwest Gamma Knife Center in the first 21 months of operation beginning in September 1994.

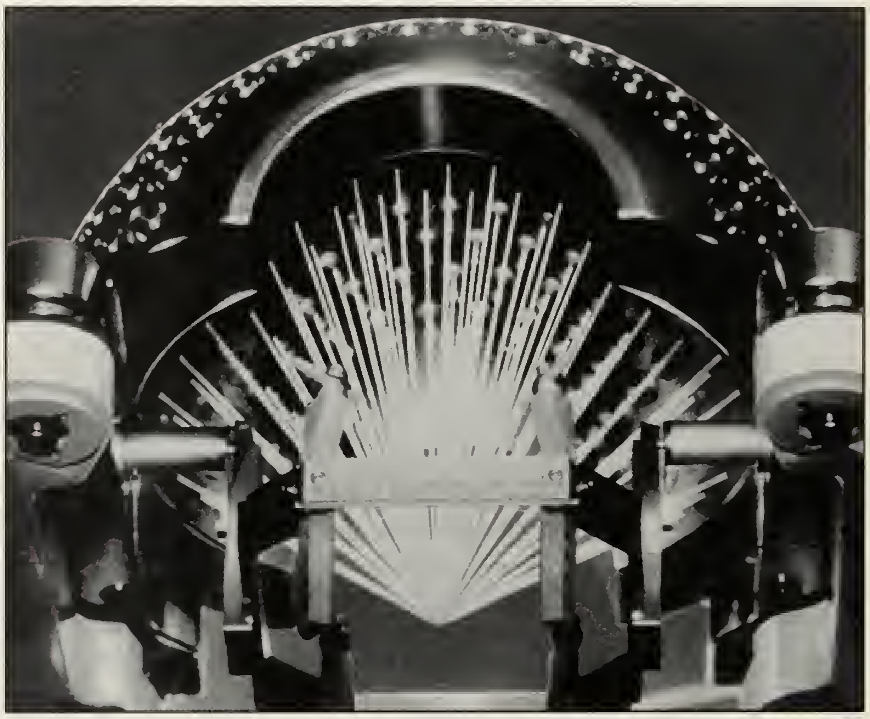

Figure 1. Photograph of the collimator helmet with Leksell Frame in place. The 201 individual beams of gamma rays converge at the center of the sphere.

Introduction

In 1951, Lars Leksell, a Swedish neurosurgeon, developed a technique for stereotactically directing beams of radiation to deep targets within the brain and called the procedure radiosurgery.[1] At present, radiosurgery can be performed with a modified linear accelerator (X-rays) the Gamma Knife (gamma rays), or a particle accelerator (proton beam).[2,3,4,5] There are six charged-particle facilities and 74 Gamma Knife units worldwide with more than 150 linear accelerators adapted for radiosurgery in North America.[2] Single dose radiosurgery differs from standard fractionated radiotherapy in a number of ways. In radiotherapy, a low dose of radiation is uniformly delivered in many fractions to a large target volume. During stereotactic radiosurgery, a single high dose of ionizing radiation is delivered, with exquisite precision, to a radiographically defined target within the skull while sparing adjacent normal tissues. Radiosurgery provides a high dose of radiation in a single treatment with rapid fall-off of radiation dose within millimeters of the target tissues. Lesion response times can vary from months to years depending upon histology (benign, malignant, AVM). Whereas, the goal of conventional microneurosurgery is complete surgical extirpation, the goal of radiosurgery is tumor control, which is defined as stable tumor size or tumor shrinkage.

The Gamma Knife

The first Gamma Knife was installed in Stockholm in 1968. The Gamma Knife utilizes 201 sources of Cobalt-60 radially distributed over a segment of a sphere, so that the emitted beams of gamma radiation intersect at the center of the sphere (isocenter) (Figure 1). Each source has an activity of approximately 30 Ci at the time of installation. The dose from an individual source is insufficient to cause tissue damage as it passes through skin, bone, and brain on route to the target. However, a therapeutic dose of radiation is attained at the center point of the sphere where the 201 gamma beams intersect. A choice of four collimator helmets allows collimation of the gamma rays into beams 4, 8, 14, or 18 mm in diameter.

Table 1. Gamma Knife Radiosurgery: Indications treated at the Midwest Gamma Knife Center. First 200 Cases.

	No. Patients
Metastasis	70
Acoustic Neuroma	30
Glial tumors	32
Meningioma	28
AVM	21
Other benign	7
Other malignant	5
Functional	4
Other vascular lesion	2
Pituitary	1
Total	**200**

Indications

Advances in neuro-imaging techniques and the increasing power of computers is responsible for the rapid growth of radiosurgery in recent years. As of February 1997, 60,000 patients have been treated at 74 Gamma Knife Centers worldwide.[6] Two hundred patients have been treated at the Midwest Gamma Knife Center in the 21 months between September 12, 1994 and June 19, 1996 (Table 1). Indications for radiosurgery include one or more of the following:

1) a medical condition that places a patient at unacceptably high risk for anesthesia and open microsurgery;
2) advanced age;
3) a lesion located within a critical brain region in which an open operative approach would likely cause a significant neurologic deficit;
4) a recurrent or persistent tumor that was not eradicated by open neurosurgery and has not responded to external beam radiotherapy;
5) a patient who does not wish to undergo traditional microneurosurgery.

A relative indication for radiosurgery is the physician's assessment that radiosurgery can control the tumor as well as surgery, yet offer a lower risk of morbidity.

Gamma Knife Procedure

On the day of treatment the Leksell Stereotactic Frame (Elekta Instruments, Atlanta, GA) is applied utilizing a local anesthetic and minimal conscious sedation (Figure 2) and appropriate imaging studies are obtained (MRI and/or CT and/or cerebral angiogram). Dose planning is undertaken with the aid of treatment planning software (Gamma Plan, Elekta Instruments, Atlanta, GA) and a high speed computer (HP 700 series) and jointly performed by the neurosurgeon, radiation oncologist, and physicist. The selection of dose is dependent upon many variables including lesion pathology, size, location, and prior radiation therapy. Typical doses range from 12 to 25 Gray units (Gy) delivered to the margin of

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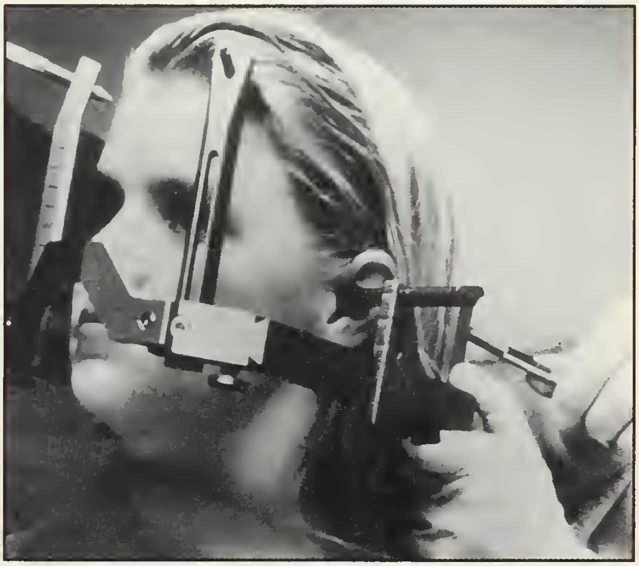

Figure 2. Application of Leksell Stereotactic Frame in the awake patient under local anesthesia.

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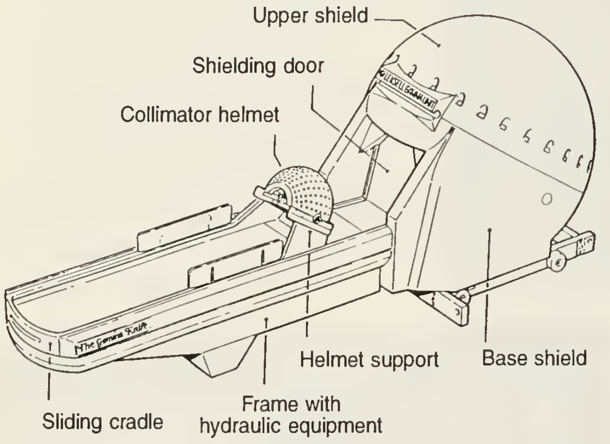
the lesion providing maximum doses of 24 to 50 Gy. Dose is decreased as target size increases to minimize potential complications. Multiple isocenters and collimators are commonly used to create an isodose configuration which tightly "fits" the lesion thereby minimizing potential radiation injury to surrounding structures. When treatment planning is complete, the X, Y, and Z coordinates of the target are set and the head frame is suspended in the collimator helmet in preparation for treatment (Figure 3). Only a small minority of patients experience minor headache or nausea after treatment and the patient may return home after a short period of observation. Restrictions on activities after Gamma Knife radiosurgery are not necessary and patients resume pre-admission activities without delay.

Figure 3. The Gamma unit with operating table.



Lesion Measurement and Survival Analysis

The maximal tumor diameter was calculated in the X, Y, and Z planes at the time of treatment and at each follow-up. Average tumor diameter (X+Y+Z/3) was computed and a positive or negative change in an average diameter of 5 mm or more was determined to be significant. Tumor control was defined as stable tumor size or interval shrinkage of the lesion. Survival curves were calculated using the Kaplan-Meier product-limit method.[7]

Metastatic Brain Tumors

Brain metastasis is the most common intracranial tumor[8] and occurs in 20-30% of patients with systemic cancer[9], with an annual incidence of greater than 100,000 cases.[10] Chemotherapy is generally ineffective and does not improve the survival of patients with brain metastases.[11] Less than one-half of all patients with brain metastases are surgical candidates because 50-80% of patients present with multiple lesions,[12,13,14] and only a portion of patients with solitary tumors have lobar lesions which are surgically accessible.

Table 2. Midwest Gamma Knife Center
Brain Metastasis by Primary Site

Primary Site	No. Patients	No. Pts. with Multiple Lesions
Lung	37	9
Breast	11	5
Melanoma	7	6
Renal	4	1
Colon	2	0
Unknown primary	2	1
Other	3	1
TOTAL	**66**	**23**

Results

We have treated 66 patients with a total of 145 brain metastases. Four patients underwent a second treatment for new lesions for a total of 70 procedures. Twenty-three patients presented with multiple metastases. The average age at treatment was 68 years (range of 19-81 years) and the most common primary was lung cancer (Table 2). Mean lesion diameter was 1.42 cm (range 0.3-3.7 cm). Mean dose delivered to the margin of the tumor was 20 Gy (range 12-26 Gy) with a mean maximum dose of 39.5 Gy (range 20-62 Gy). Radiographic follow-up was obtained every three months and was available for a total of 70 lesions with a median follow-up of six months (range 3-18 months). At last follow-up 24 (34%) lesions had decreased in size, 38 (54.3%) had not changed significantly and 8 (11.4%) increased in size, for a total tumor control rate of

88.8% (Figure 4). There was a median survival of eight months following Gamma Knife radiosurgery (Figure 5). One patient underwent craniotomy following Gamma Knife radiosurgery for tumor growth. Documented radiation necrosis occurred in two patients who had received prior whole brain radiation therapy (WBRT). Of these two patients, one required surgery and radiographic changes spontaneously resolved without clinical sequelae in the other.

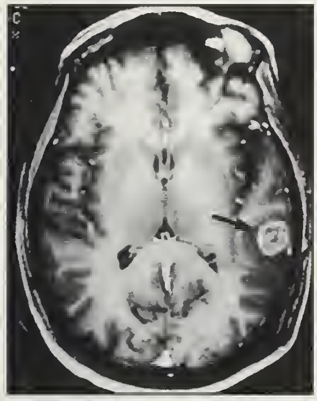


Figure 4A. Metastatic endometrial cancer in the temperal-parietal region of the brain (arrow).

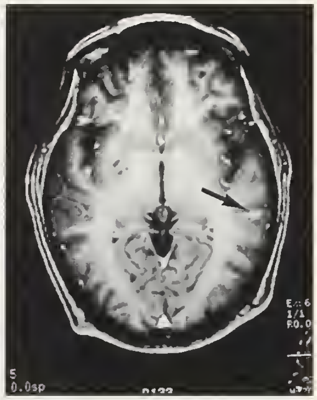
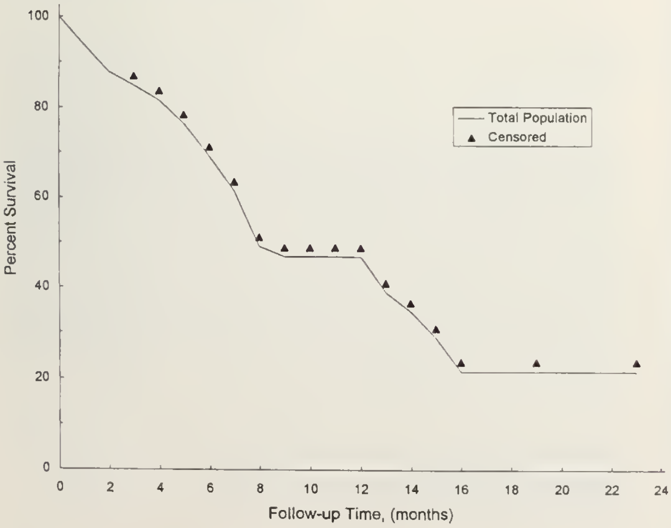


Figure 4B. Same patient seven months following radiosurgery (22 Gy to the tumor margin, 44 Gy maximum dose.)

Figure 5. Survival curve of patients with metastatic brain tumors following Gamma Knife radiosurgery. Median survival was eight months.



Discussion

Without treatment, the prognosis for patients with single brain metastases is dismal. Options for treatment include surgery, WBRT, radiosurgery or a combination of these modalities. In a prospective, randomized study of brain metastasis, Dr. Roy Patchell and colleagues established the benefit of surgery + WBRT (median survival = 40 weeks) over WBRT alone (median survival = 15 weeks).[15] A review of retrospective studies reveals that median survival following surgery + WBRT for single metastasis approximates six months (range 4-25 months)[16,17,18,19,20] compared with a median survival of 6.5-15 months for radiosurgery.[21,22,23,24] Table 3 provides an overview of median survival with different treatment modalities. This data must be interpreted with the knowledge that most of the information comes from retrospective studies and that median survival is affected by many variables including histology, extent of systemic disease, number of intracranial lesions, performance status at the time of treatment, time from primary diagnosis, age, and lesion size.[25,26,27] Local recurrence after Gamma Knife radiosurgery occurs in 4-18% of patients,[21,22,24,28] compared with local recurrence after surgery + WBRT in approximately 25% of patients, and a local recurrence as high as 85% in patients treated with only WBRT or surgery alone.[15,25,26,29]

Controversy remains with regard to the need for concomitant WBRT at the time of stereotactic radiosurgery. Standard practice has been to provide WBRT for patients with brain metastases in the hope of sterilizing micrometastases that can not be identified on imaging studies. With the wide availability of MRI and a finite risk of delayed radiation encephalopathy,[30,31] some investigators have begun to question the need for "up front" WBRT.[23,29] Our present practice is to offer radiosurgery as an alternative to surgery and WBRT to all patients who present with single or multiple cerebral metastasis without mass effect. Patients with large lesions and/or edema producing significant mass effect require surgical debulking. Re-treatment with radiosurgery is considered for patients with stable systemic disease, particularly if there is only one site of progression. WBRT remains an option when there is

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progression at multiple sites within the brain or in patients with advancing systemic disease. An additional advantage to stereotactic radiosurgery is its effectiveness in management of melanoma and other tumors which are radioresistant to conventional fractionated WBRT.[32]

Table 3. Alternative Therapies for Brain Metastases: Median Survival

Therapy	Median Survival (wks)
No treatment	4
Steroids alone	8
WBRT only	15
Surgery + WBRT	26-40
Gamma Knife Radiosurgery	30-66

Acoustic Neuroma

Acoustic neuromas (vestibular schwannomas) are schwann cell tumors that typically arise from the vestibular portion of the eighth cranial nerve. The most common presenting symptoms are unilateral hearing loss, tinnitus, and imbalance. Gadolinium enhanced MRI is the best way to detect acoustic neuromas with the ability to identify tumors as small as 5 mm in diameter. The natural history of acoustic neuromas has been evaluated by a number of investigators utilizing retrospective analysis of untreated patients. These studies suggest that most acoustic neuromas will enlarge within one to two years, if not treated. The growth rate averages 1-2 mm per year with a wide variability in individual tumor growth that can range from 0-10 mm per year.[33,34]

Results

This analysis includes 30 patients with acoustic neuromas treated at the Midwest Gamma Knife Center. Average tumor diameter ranged from 0.5 cm to 4.3 cm with a mean of 1.8 cm. Patients' ages ranged from 35 to 84 with an average age of 57 years. The mean dose of radiation delivered to the margin of the tumor was 12 Gy (range, 10-18 Gy) with a mean maximum dose of 24 Gy (range 17-36 Gy). Multiple irradiation isocenters were used in all patients (average, 7.5 per patient; range, 2-16). Clinical follow-up of more than six months is available in 27 patients with a mean follow-up of 14 months. No patient has experienced transient or permanent facial weakness. Imaging follow-up of more than six months is available in 18 patients with a mean follow-up of 11 months (range, 6-18 months). Seventeen tumors have remained stable in size without significant growth or shrinkage and one tumor has decreased in size (Figure 6). Only four patients with serviceable hearing prior to treatment have been followed for more than six months precluding useful analysis at this time.

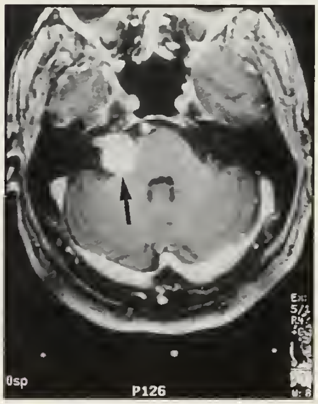

Figure 6A. Acoustic neuroma (arrow).

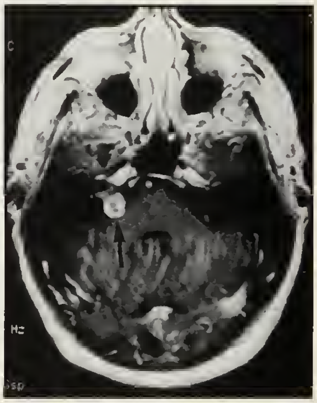

Figure 6B. Same patient 12 months following radiosurgery (12 Gy to the tumor margin, 24 Gy maximum dose.)

Discussion

Microsurgical techniques used for the removal of acoustic neuromas have been steadily refined over the past two decades. Mortality has been minimized to under 1% and current efforts are directed toward preservation of facial and acoustic nerve function. Hearing preservation is a feasible objective when tumors are smaller than 2 cm in diameter. Successful preservation of hearing ranges between 30% and 50% of selected patients undergoing surgery at special centers with experienced staff.[35,36] The facial nerve is also at risk for injury during microsurgical resection of acoustic neuromas. Success at preserving facial nerve function is proportionate to tumor size and ranges from a low of 35% in tumors > 4 cm in diameter to a high of 85% in tumors < 2 cm in diameter.[37]

Tumor control, defined as absence of tumor growth or delayed reduction in tumor volume following Gamma Knife radiosurgery, is reported in the range of 86% to 95%.[38,39,40] Hearing loss may occur up to 21 months after Gamma Knife radiosurgery in less than 50% of cases[41] and facial nerve injury after Gamma Knife radiosurgery is rare. When compared to microsurgical resection of acoustic neuromas, Gamma Knife stereotactic radiosurgery is a low risk, effective, and less costly management strategy that should be considered by all patients prior to making final treatment decisions.

Arteriovenous Malformation

AVMs are congenital lesions which arise between the fourth and eighth week of embryonic life with persisting connections between arterial in-flow and venous out-flow without an intervening capillary bed. Patients most commonly present with hemorrhage but may also come to evaluation because of headache, seizures or progressive neurological deficit.[42] The natural history of AVMs has been extensively evaluated with a 2-4% per year risk of hemorrhage and 1% per year risk of death.[43,44] Each episode of bleeding carries a 10-30% risk of permanent morbidity and 10-15% risk of death.

Treatment Options

Current treatment options for AVMs include microsurgical resection, embolization, and radiosurgery. Embolization alone is rarely successful and is used primarily as an adjunct to microsurgery and radiosurgery.[45] The risk of microsurgery depends upon lesion size, location, venous drainage pattern, and presence of deep feeding vessels.[42,46] For smaller AVMs in non-eloquent areas, microsurgery has a 2-4% risk of significant morbidity and mortality which increases to greater than 50% for patients with the most difficult lesions.[46]

Discussion

Whereas successful microsurgical obliteration of AVMs results in an immediate cure, the effects of ionizing radiation on blood vessels accrues over months to years. Initially, endothelial cells undergo degeneration and necrosis followed by increased fibroblastic activity, deposition of collagen in vessel walls,

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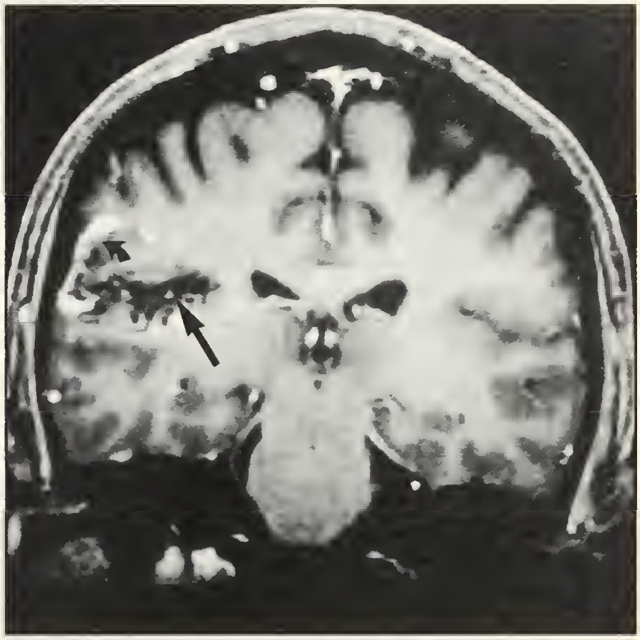

Figure 7A. Arteriovenous malfornation in the Sylvian fissure with the signal void nidus (small arrow) and a large draining vein (curved arrow).

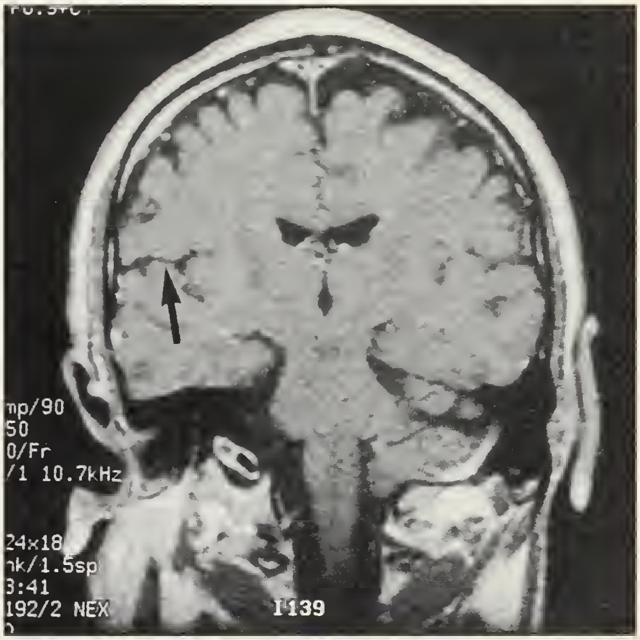

Figure 7B. Same patient 15 months following radiosurgery (20 Gy to AVM margin, 40 Gy maximum dose). Neither the nidus nor draining vein is readily visible.

Continued from page 351

fibrosis of adventitia, and ultimately occlusion of the vascular lumen. As is the case with microsurgery, radiosurgery is most successful in patients with smaller lesions located in non-eloquent areas of the brain.[38,47,48,49] Approximately 80% of patients will achieve complete obliteration within three years of treatment. Obliteration rates range between 70% for lesions greater than 3 cm in diameter to 100% for lesions less than 1 cm in diameter with the option for re-treatment after three years in patients with residual AVM.[38,47,48,50,51] There is an approximately 3% risk of significant morbidity from radiation injury and patients remain at risk for bleeding until angiographic obliteration is documented.

We have treated 21 AVMs in our first 200 patients, ranging in size from less than 1 cm in diameter to greater than 5 cm in diameter. Preliminary MRI results are encouraging and reveal decreased lesion sizes but meaningful data analysis will require longer follow-up (Figure 7). For patients with lesions in eloquent areas of the brain, patients with concurrent medical illnesses, patients at risk from general anesthesia, and in patients who refuse surgical intervention, radiosurgery is an excellent option. With virtually no risk of mortality and minimal risk of morbidity, patients with an arteriovenous malformation and a life expectancy of greater than five years should be considered for radiosurgery.

Conclusion

Gamma Knife radiosurgery is often an effective, safe, and less costly alternative to traditional microneurosurgery for tumors, AVMs, and trigeminal neuralgia. Radiosurgery is accepted by the neurosurgical community as an important adjunct in the management of neurosurgical diseases. It offers patients a non-invasive alternative for various conditions and provides new options for the patient with "inoperable" disease. The future role of Gamma Knife radiosurgery will be determined by careful follow-up of previously treated patients and the results of prospective randomized clinical trials. MoMed

Editorial Comment

This review of the experience using the Gamma Knife radiosurgery system at the Midwest Gamma Knife Center supports the literature documenting the effectiveness and safety of stereotactic radiosurgery in the treatment of a variety of intracranial disorders. Moreover, the exact role for radiosurgery is still being established in some diseases, such as trigeminal neuralgia. In view of the power of radiosurgery to help patients, it should be pointed out that stereotactic radiosurgery can be delivered by linear accelerator-based systems which have achieved clinical results comparable to Gamma Knife. Both systems use stereotactic techniques to precisely deliver radiation to intracranial targets. Future avenues for investigation include frameless stereotaxis and fractionated radiosurgery.

Edward V. Colapinto, Assistant Professor
Division of Neurosurgery
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Why Be Just a Doctor When You Can Be a Spin Doctor?

Tom Bennett, Executive Vice President, Missouri State Medical Services
Lizabeth R. Starnes, MSMA Director of Communications

Public relations affects almost everyone who has contact with other human beings. All of us, in one way or another, practice public relations daily. For an organization, every phone call, every letter, every face-to-face encounter is a public relations event.

To some, the concept of public relations conjures up "slick" professional activities spinning damage control techniques via the media as a result of a major calamity. Unfortunately, the term *public relations* has a historically negative and reactive connotation, when, in fact, its principles deal with the *technique* and *art of communication.*

Seeking a Definition

In your basic Marketing 101 class, you would be taught that public relations is a very small part of one of the four "Ps" of marketing: product, price, place, and promotion. Public relations fits nicely into the fourth quadrant of this equation: promotion. But so does advertising, personal selling, propaganda, corporate communications, public affairs, and publicity.

So how does one define the very art of communicating with your publics?

Public relations is the deliberate, planned, and sustained effort to establish and maintain mutual understanding and communication between an organization and its publics.[1]

The key is management; the very management of your communication to your publics. Underlying the definition is an unstated word - performance. Without proper performance, good public relations is impossible. In other words, first lay the egg, then cackle.

But wait . . . you're a physician. Why should you know the practice of public relations? After all, don't you just want to practice medicine, not public relations?

Why be just a doctor when you can be a spin doctor?

The following case study describes how the core principles of public relations are not only useful, but are vital in medical practice. The case study format will help to highlight and contrast the use of public relations, particularly in medical group development, physician network development, and new service development.

The Case

In 1995, two young physicians in rural Missouri decided they were not going to survive in their present solo practices. Both were adamantly opposed to becoming employees of the local hospital system. They decided to develop a multispecialty group as the anchor for a full service network.

While discussing this concept between themselves, the dialogue helped to refine and define the idea. They committed this concept to paper through a vision statement.

This vision statement was their first act of public relations. This vision statement was communication between two publics, the two physicians. The discipline of writing a vision statement helped to clarify and communicate to each other their dreams and ambitions.

Rather than impulsively take the vision statement and attempt to recruit other "disciples," they took a more systematic and disciplined approach. They hired a consultant to complete an overview document describing their health care model, the range of services, the service area, the market segments to be targeted, a statement of purpose, statement of values, legal vehicle, and potential partners. This planning document was essential in moving the concept to its next formative stage, the recruitment of the core group of committed physicians who had been identified and profiled.

Questions rapidly began filling the paper.

What is the most effective and efficient way to recruit? Between cases? In the doctors lounge at the hospital? In the corridor of the hospital while making rounds? On the golf course?

Answer: None of the above!

With the help of the consultant, the founding physicians carefully and methodically planned a professional presentation. The areas included:

- The preparation of a cover letter and invitation to the presentation.
- The selection and targeting of the core group.
- The formatting of the overview document.
- The preparation for the presentation.
- The date and time to ensure maximum attendance.
- The setting of the presentation.
- The training of the presenter or spokesperson.
- The signing of the letter of commitment.
- Defining the next step.
- The total time including dinner not to last more than 2 1/2 hours.

Out of the seven physicians who attended the presentation, five signed letters of intent and became the core group, the steering committee.

With the recruitment of this core group, and through a process of continued and focused dialogue with assistance from the consultant, the overview document evolved into a business plan. This became the single most important document of this fledgling organization. This document would be the axis on which all major decisions would be made, the vehicle of communication among the physicians' group, and the reference point for all internal and external communications with the various publics.

The business plan described the nature of the provided business and services, where they will be provided, how they will be provided, why this organization will be successful or what niche it will serve, who will purchase services, why they will purchase services, the legal vehicle, the governance and management, the implementation plan, financial projections, goals, timeliness, and strategies.

Targeting the Publics

Important to all public relations activities: the business plan is a comprehensive guide that is used both internally and externally to launch and maintain an organization.

The publics targeted in the business plan included:

- Physicians for Recruitment
- Business Coalition
- Ancillary Providers
- Vendors
- Investors
- Insurance Underwriters
- Banks

From a public relations viewpoint, the next steps were critical: selecting a name for the organization, filing the articles of incorporation with the Secretary of State, choosing the legal vehicle, and nominating a governing body.

What is in a name? The name is the *identity* of the organization and should describe the type of service and be used as a point of differentiation from other similar organizations. This newly-formed group chose the name "Physicians Heathcare Network" (PHN).

Proactive, Not Reactive

Once the articles had been prepared and filed with the Secretary of State, PHN became a public entity. In order to avoid any misconceptions, false information, or speculation about the formation of PHN, the steering committee prepared a press release with the assistance of the consultant. The press release described the name of the organization, the officers, and the mission. The release was sent to the following publics: the local medical society, the local hospital (administration/board/medical officers), radio stations, television stations, newspapers, home care providers, rehabilitation providers, the chamber of commerce, the civic leadership, and key company executives.

Rather than an external organization attempt to explain the nature and focus of this new organization to the public-at-large, it is imperative from the very beginning that the group practice *proactive public relations* so the method of communication is truthful, consistent, and concise.

The press release also identified the responsible party to contact for further information. PHN established a strict policy that there would only be one spokesperson, and all inquiries and questions were directed to this individual who had been coached by the consultant to articulate the position of the group.

PHN continued its recruitment plan both for partners in the group and providers in the network. The overview and business plan became invaluable tools for this purpose.

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Raising the Capital

The group now faced its first major hurdle: how to raise the capital to develop the vision. One significant aspect of the business plan was the strategy to develop immediately a free standing surgery center whose earnings could be used to leverage the capital needed to continue the development of their plan: recruitment of physicians, medical office building, lab, and the rehabilitation and imaging center. PHN applied for a Certificate of Need (CON) and solicited the consultant to assist through this very complex and political process.

Prior to applying for the CON, the PHN group met with key, senior medical staff members to inform them of their intent to file for the CON for the surgery center and solicit their support. This important meeting was carefully planned and rehearsed. The majority of the physicians in attendance were in support. Hospital employed physicians were in opposition.

The PHN group had scheduled another meeting with the executive committee of the hospital's board of directors. The purpose was to inform the hospital of PHNs intent to apply for the CON to build the surgery center, and to solicit the hospital as a partner. Unfortunately, word of the pending CON application had been leaked to the hospital and PHN physicians were unprepared for the onslaught that came from the hospital and its "hired guns." The hospital waged a character assassination campaign against PHN, accusing the physicians of being self-serving, self-centered, greedy, and intent on closing down the hospital and putting many employees of the hospital out of work.

Setting the Record

At the insistence of the consultant the same day that the CON was filed, PHN issued a detailed press release to educate on the nature and intent of PHN building and operating a surgery center to the following publics: the general public, hospital, civic leaders, business leaders, third-party administrators, managed care organizations, insurance companies, and all of the physicians in the community. See Figure 1.

Communicating the Truth...Well-Told

In preparing this communiqué, PHN followed the art of practicing proactive and positive public relations:

☞ The organization that initiated the news release;

☞ The name, address, and phone number of the organization's spokesperson;

☞ Clear, precise statements of fact or intent;

☞ The release is not written in critical or combative format and it is not attacking the hospital, when in fact, it mentions the hospital as a "partner;"

Figure 1.

NEWS RELEASE

Physicians Healthcare Network
CONTACT: DR. ALEX FIELDGOOD
(573-222-2222)
1530 South Hyde Park
Freetown, MO 63117

FOR IMMEDIATE RELEASE

PHYSICIANS TO BUILD SURGERY CENTER

A group of Freetown physicians recently formed Physicians Healthcare Network, a physician-owned and -directed multispecialty group. This newly formed organization has filed a letter of intent with the Missouri Certificate of Need Program to construct and operate a free standing surgery center to be located on 99th St., Freetown, Mo.

Alex Fieldgood, MD, one of the founding members of the Physicians Healthcare Network, indicated a group of concerned physicians have taken a bold and proactive step forward in building this ambulatory surgery center, particularly in response to the challenges of managed care.

According to Dr. Fieldgood, the goals of this initiative are: to deliver high quality care to their patients, to provide outstanding service, and to bring value to those who purchase health care.

Dr. Fieldgood stated, "As independent physicians it is our responsibility to remain patient advocates, and that is why this patient-focused initiative will greatly benefit the community and the patients we serve. This ambulatory surgery center will provide patients with the opportunity to receive high quality care at more affordable rates in a state-of-the-art facility. The surgery center will also afford patients more flexibility and more convenience in a less institutional setting." Fieldgood also said PHN requested the hospital become a partner in this important community venture.

This surgery center has been designed to provide surgical services in a more efficient manner to allow highly competitive pricing to local companies for packaged services, while providing greater access to all patients.

Upon approval from the Missouri Health Facilities Review Committee, construction of the surgery center should begin in the summer of 1997 and be completed by January 1998.

###

☞ It shows the physicians as advocates of the patients;

☞ This initiative is for the good of the community and will serve the community by bringing state-of-the-art service to the community;

☞ The communiqué benefits the business community by reducing cost and maintaining quality;

☞ The release is meant to counteract the negative campaign by the hospital.

The spokesperson for PHN, Dr. Fieldgood, was briefed on how to effectively deal with questions from the media. To be an effective spokesperson, you must be the very embodiment of the organization's vision, the chief advocate and negotiator with other organizations, and the builder of networks of external relationships to provide useful ideas, resources, support and information for your organization. "The spokesperson must become both the medium and the message that expresses what is worthwhile, attractive, and exciting about the future of the organization."[2]

With the CON for the surgery center now filed, the documentation for the justification and need for the surgery center began in earnest. This documentation also became the basis for PHNs public campaign to build the surgery center.

Communicate the Facts

The cornerstone of PHN's argument consisted of the following facts:

☞ There was no free standing surgery center in the community, the nearest was more than 50 miles away.

☞ The charges for outpatient surgery at the local hospital were not competitive; provided documented patient bills.

☞ The management of the outpatient surgery unit at the hospital was not efficient; provided documented turnover times of operating rooms.

☞ More than 40% of medical revenue was leaving the community and going to the neighboring urban area that had a negative impact on the local economy.

☞ Patients under contract with managed care companies had to travel over 50 miles to the urban surgery center for services; provided documented agreements.

☞ Residents would prefer not to travel 50 miles for services and would prefer the convenience of being treated locally; provided documented survey results.

☞ The surgery center would improve the economy of the community and increase market share to the hospital by attracting patients into its service area; provided documented survey results from surrounding communities.

☞ The major employers and the local business coalition on health care were in full agreement with the center; provided documented letters of support.

☞ The local state representatives were in support of the initiative.

☞ Local civic leaders and the leaders of the surrounding communities wrote letters of support.

Public Relations Techniques

This case demonstrates the art of communicating with the interested publics and using facts and documentation to prove the viewpoint of PHN.

☞ Documented facts supporting the initiative, particularly economic facts.

☞ Documented hardship and inconvenience of the residents, particularly for the elderly, to travel 50 miles.

☞ The identification of the real competition which was the neighboring urban area.

☞ The politics of support to improve the local community.

☞ The lobbying or persuasion of the local and state politicians particularly the members of the CON board.

☞ The well-prepared presentations by PHN members to targeted groups: Rotary, Kiwanis, Lions, chamber of commerce, school board, and church groups.

☞ A clear, concise, and consistent message from PHN to all publics.

☞ Articulate spokesperson.

The Proof is in the Pudding

The hard work and proactive public relations of PHN paid off. The CON board approved the building of the surgery center despite the opposition from the local hospital, and PHN continues to implement its vision. **MoMed**

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2. Nanus B. *Visionary Leadership*. Jossey-Bass, California, 1992, p 14.

Missouri State Medical Services is a wholly-owned for-profit subsidiary of MSMA designed to assist physicians with their transition to a market dominated by managed care considerations. Tom Bennett may be reached by calling ***1-800-633-1516.***

The University of Missouri-Columbia Medical Alumni honored physicians during a recent awards luncheon. **Lenard Politte, MD,** Columbia, a cardiologist at the Missouri Health Institute who also serves as president of the MU Medical School Foundation, received a service award.

Honory alumni awards were presented to **Jack Curtis, MD,** Columbia, MU professor of surgery; **Donald Silver, MD,** Columbia, W. Alton Jones Distinguished Professor and chairman of surgery at MU; and **Daniel O'Sullivan, MD,** St. Louis, general and thoracic surgeon.

Michael Good, MD, Springfield, traveled to Manaus, Amazonas, in northern Brazil with Christian Missions Unlimited (CMU). While there he met a three-year-old boy who needed a colostomy. Good contacted Dr. Alberto Pena, chief of pediatric surgery at Schneider Children's Hospital in New Hyde Park, NY, who agreed to donate his usual surgical fee. Good and CMU raised money to bring the boy and his family to New York for the surgery.

In Memoriam

Carleton J. Lindgren, MD, 62, Independence, died April 9, 1997. Dr. Lindgren was a graduate of Iowa State University and the University of Maryland. He practiced in Independence for 25 years and in Lee's Summit for the past three years. Dr. Lindgren, a psychiatrist, was a member of the Missouri State Medical Association.

William C. Critchlow, MD, 82, Sikeston, died April 16, 1997. He was a graduate of Murray State University and St. Louis University Medical School. Dr. Critchlow practiced in Sikeston from 1947 until he retired in 1985. Dr. Critchlow, a family practitioner, was a member of theMissouri State Medical Association.

G.W. Winn, MD, 90, Boonville, died April 16, 1997. He was a graduate of Washington University School of Medicine and practiced medicine from 1933 to 1981. Dr. Winn, a general surgeon, was a member of the Missouri State Medical Association.

Carl E. Aulenbacher, MD, 57, Fort Lauderdale, Fla, died April 19, 1997. Dr. Aulenbacher, a general surgeon, was a member of the Missouri State Medical Association.

Paul C. Morton, MD, 79, Springfield, died April 24, 1997. Dr. Morton was a graduate of Drury College and St. Louis University. He practiced medicine in Springfield for 35 years. Dr. Morton, an internist, was a member of the Missouri State Medical Association.

Henry Coles Dugas, MD, 80, St. Louis, died May 4, 1997. Dr. Dugas earned a bachelor's degree from Johnson C. Smith University in Charolotte, NC, completed postgraduate work at the University of Michigan in Ann Arbor and received his medical degree from Howard University in Washington. He was in private practice in St. Louis for 45 years. Dr. Dugas, a general practitioner, was a member of the Missouri State Medical Association.

Fred Irwig, MD, 98, Prairie Village, KS, died May 6, 1997. He received his medical education in Germany at the university medial schools of Konigsberg, Greifswald, Freiburg, Hamburg, and Munich. He practiced medicine in Kansas City, Mo. from 1924-1982. Dr. Irwig was a member of the American Medical Association, Missouri State Medical Association, Metropolitan Medical Association, American Medical Association of Vienna, Austria, and a Fellow of the College of Allergy and Industrial Medicine.

New Members

MSMA Only

Dee Anna Glaser, MD - D
1402 S. Grand Blvd.
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Cape Girardeau

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Univ of Louisville; 1991

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Cynthia Caputo, MD - OBG
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Jefferson Med Col-Philadelphia; 1991

Anup Khatana, MD - OPH
3800 W. 75th St.
Prairie Village, KS 66208
Wayne St Univ-Detroit; 1991

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Univ of MO-Columbia; 1990

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Fuhs/The Chicago Med School; 1989

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Elie Azrak, MD - IM
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Fac of Med Univ of Aleppo-Syria; 1992

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Ponce Med Sch Ponce-Puerto Rico; 1996

Marilyn Brown, MD - PD
11000-A Sugar Pines Ct.
Florissant, MO 63033
Meharry Med Col-Nashville; 1996

Students - University of MO-Kansas City

Sarah Fischer
Alia Iqbal

AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs.

Sandra Ahlum, *Hannibal*
John Bumberry, *Springfield*
James Conant, *St. Joseph*
Luke Dlabla, *Independence*
Michael Fedotin, *Kansas City*
Charles Goeking, *St. Joseph*
Glenn Gordon, *Mexico*
Dennis Hite, *Lebanon*
Marty Kanne, *Kansas City*
Bernard Melia, *Kansas City*
Edward Schlafly, *Chesterfield*
Eugene Taylor, *St. Louis*
Aturo Tenorio, *Stanberry*
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22 thru 24 - *Columbia*: The Howard A. Rusk International Symposium on Neurological Rehabilitation. 19.2 credit hours. Call University of Missouri-Columbia CME office 573-882-0366.

September

5 thru 7 - *St. Louis*: 4th Annual Current Topics in Cardiothoracic Anesthesia. Call Washington University School of Medicine 314-362-6891.

18 thru 20 - *St. Louis*: Contemporary Cardiothoracic Surgery. Call Washington University School of Medicine 314-362-6891.

October

17 thru 19 - *St. Louis*: Practical Issues in Leading-edge Radiology II. 25.5 credit hours. Call Linda Macker 314-362-2916.

25 - *Joplin*: COBRA/EMTALA and Anti-Trust Issues. 3.0 credit hours. Call Sandy Sooter, St. John's Regional Medical Center, Joplin 417-625-2142.

November

7 & 8 - *St. Louis*: 25th Annual Kilo Diabetes Symposium. Current Topics in Diabetes, Endocrinology and Vascular Disease. Call Beverly Cantoni 314-434-6500.

7 thru 9 - *Branson*: Missouri Academy of Family Physicians's Fall Conference. 10 credit hours.

13 & 14 - *St. Louis*: 23rd Annual Symposium on Obstetrics and Gynecology. Call Washington University School of Medicine 314-362-6891.

December

6 - *St. Louis*: Cardiology Seminar. Call Washington University School of Medicine 314-362-6891.

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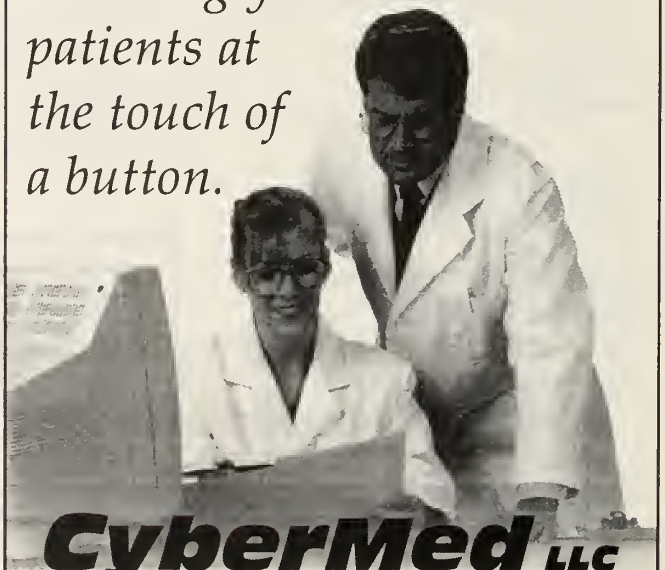

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MISSOURI MEDICINE

VOLUME 94, NUMBER 8

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Members of the Missouri State Medical Association currently practicing medicine are listed alphabetically by specialty. This roster includes the city in which the physician practices and the code number representing the component medical society to which the physician is a member.

Roster of Members by Component Society 475

All members of the Missouri State Medical Association are listed alphabetically by component medical society. This roster includes the member's medical specialty code, address and phone number. Medical students are listed only by name, alphabetically by medical school.

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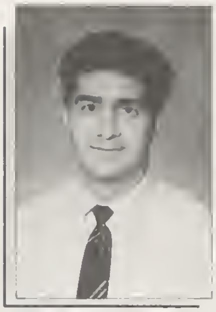

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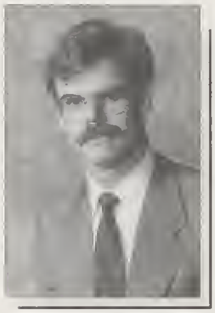

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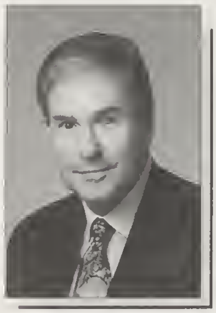

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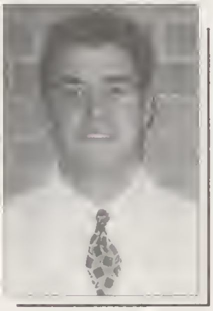

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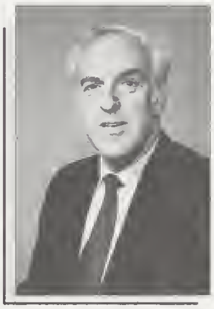

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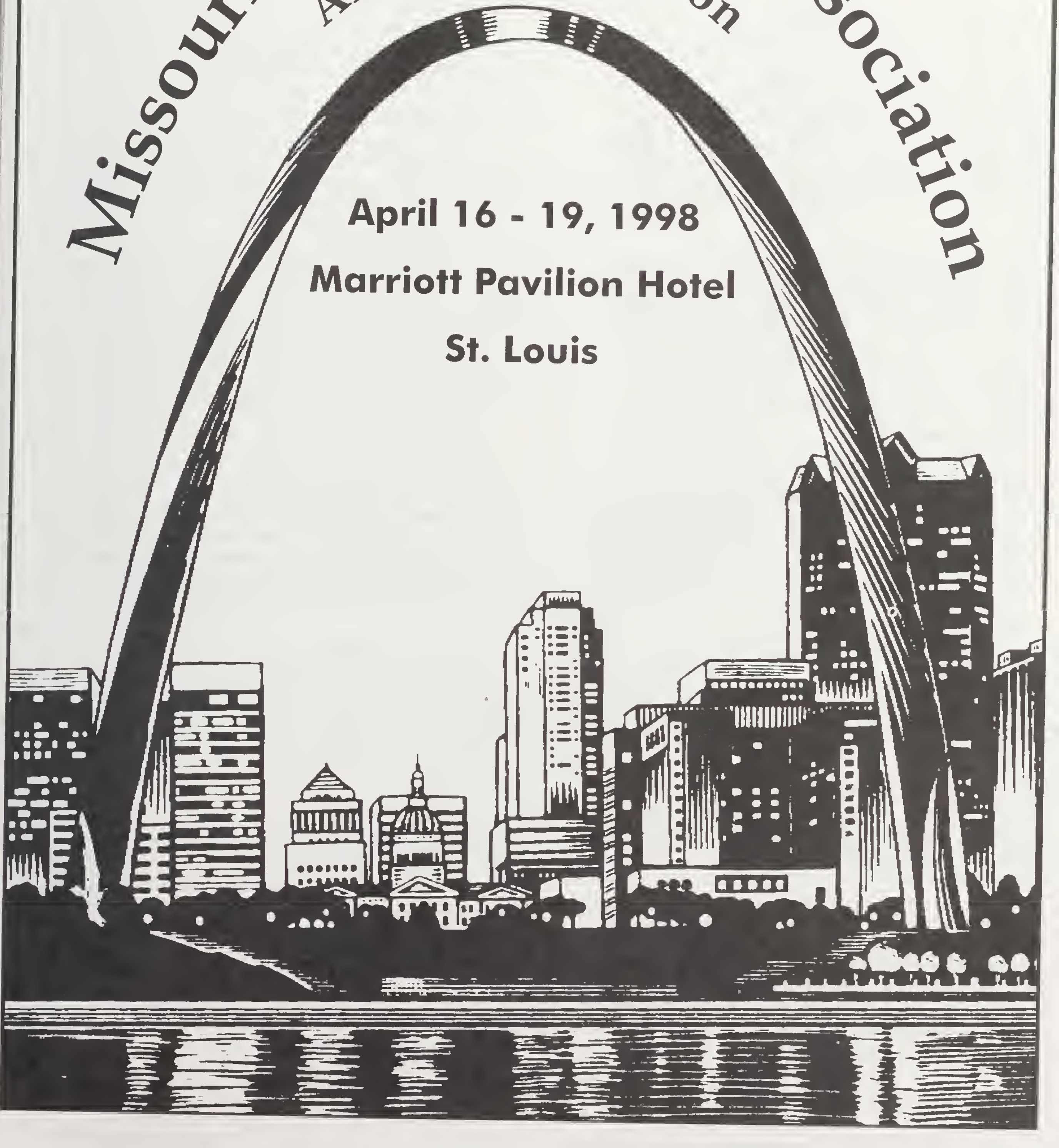

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MSMA offers value for your membership dues, the lowest state medical association dues in the nation! This membership guide and the following pages explain your benefits as a MSMA member. Contact names and telephone numbers are given, where available. For more information on membership, please contact MSMA at 573-636-5151.

❖ Subscriptions to *Missouri Medicine*, *Progress Notes*, and the *Legislative Report*

MSMA members receive *Missouri Medicine*, the monthly scientific journal that informs you of the latest medical, socioeconomic, and technological developments. *Progress Notes* alerts members monthly to current trends in medicine that affect your profession and practice. During the legislative session you receive the *Legislative Report*, a weekly review of activities from the Missouri Capitol. *Contact Barbara Crader at 573-636-5151 for address changes.*

❖ Physician's Guide to Law and Medicine

MSMA offers the Physician's Guide to Law and Medicine to assist members in understanding the laws that affect the practice of medicine. Updated in 1997, all members receive the comprehensive guide and regular updates. *Contact Tom Holloway at 573-636-5151 for more information.*

❖ MoMed Net and MSMA's World Wide Web Site: http://www.msma.org

Access to the Internet is easy for MSMA members. Through an agreement with Sprint, MSMA will supply necessary software at low prices providing unlimited access to the Internet. The MSMA World Wide Web site features information on legislative, scientific, and socioeconomic issues that is password protected, secure, and educational. *Contact Ron Ellison at 573-636-5151 for more information.*

❖ Missouri State Medical Services, Inc.

This medical practice management organization is designed to provide high quality, professional, and comprehensive practice management services to MSMA members at affordable and competitive rates. *Contact Thomas Bennett at 1-800-633-1516 for more information.*

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- **Assisted the Missouri Legislature's Joint Interim Committee on Managed Care** and provided valuable testimony on behalf of physicians as it drafted recommendations and modeled legislation.
- **Worked tirelessly to help pass House Bill 335,** the sweeping Managed Care Reform Act, which banned gag clauses and placed various restrictions on the activities of managed care organizations.
- **Developed the *Physician's Guide to Law and Medicine*** to assist members in understanding the laws that affect the practice of medicine.
- **Developed the MSMA World Wide Web site** that features information on legislative, scientific and socioeconomic issues. ***http://www.msma.org.***
- **Introduced "Easy Returns," a program** that provides regulated destruction and documentation for physicians' unused pharmaceutical samples and narcotic drugs.
- **Maintained the highly effective "Key Contact"** network which encourages physicians across the state to stay in close contact with their lawmakers.
- **Sponsored the "Physician of the Day"** program at the Capitol.
- **Maintained contact with Missouri's Congressional Delegation** as lawmakers in Washington, D.C. considered health care reform, tort reform, and countless other federal rules and regulations.
- **Published *Progress Notes*, a monthly newsletter** designed to inform you and your colleagues of current events that affect your profession and practice.
- **Sponsored practice management workshops** for physicians and office staffs at locations around the state.
- **Introduced the MSMA Gold MasterCard** which offers a higher credit line, unmatched services, and features a free HIV supplemental income protection policy.
- **Maintained a special liaison committee** to improve communications between the medical community and the State Board of Registration for the Healing Arts.
- **Monitored the fortnightly *Missouri Register*** for new government regulations concerning health care.

Missouri State Medical Association

- **Published and distributed "A Woman's Choice: Alternatives in the Treatment of Breast Cancer"** to hospitals and clinics statewide.
- **Represented your interests at numerous public hearings** on a variety of medical issues.
- **Served more than 100 physicians through** the Missouri Physicians Health Program.
- **Sponsored Missouri State Medical Services, Inc.,** which offers practice management consultative services to physicians.
- **Accredited Missouri institutions and organizations** as sponsors for continuing medical education.
- **Helped defeat scores of detrimental legislative proposals** such as legalized lay midwifery, chiropractic prescriptive authority, and much, much more.
- **Supported the MSMA Physician Placement Service** which matches interested physicians with communities seeking qualified applicants.
- **Provided Category 1 CME credit** for scientific programs sponsored by 21 specialty organizations during the MSMA's 1997 Annual Meeting in Kansas City.
- **Managed the self-sustaining 501(c)(3) Missouri State Medical Foundation** which provided $270,000 in loans this year to 60 Missouri Medical Students, and has supplied students with more than $5 million since its inception.
- **Responded to numerous requests for medical information** from the media.
- **Published monthly issues of *Missouri Medicine*,** the journal of the Missouri State Medical Association.
- **Jointly-sponsored the seventh annual Medical-Legal Symposium** to educate members on important medical-legal issues.
- **Monitored nearly 1,300 bills during the 1997 General Assembly,** nearly 300 of which were related to health care.
- **Represented your interests at meetings** of the Missouri PRO Board of Directors.
- **Developed Physicians Resource Network,** a management services organization designed to assist physicians with high quality goods and professional services.
- **Provided counsel to the state's 34 Senators and 163 Representatives** on health care legislation under consideration.
- **Created an "Affiliate Membership,"** a category which benefits those who contribute to health care through employment to MSMA members and component medical societies.
- **Responded to numerous requests for information** from physicians and their staffs.
- **Partnered with TaxResource, Inc.,** a national tax audit service that specializes in complete, highly professional medical audit defense for MSMA members.
- WAS THE VOICE OF MORE THAN 6,000 PHYSICIANS STATEWIDE

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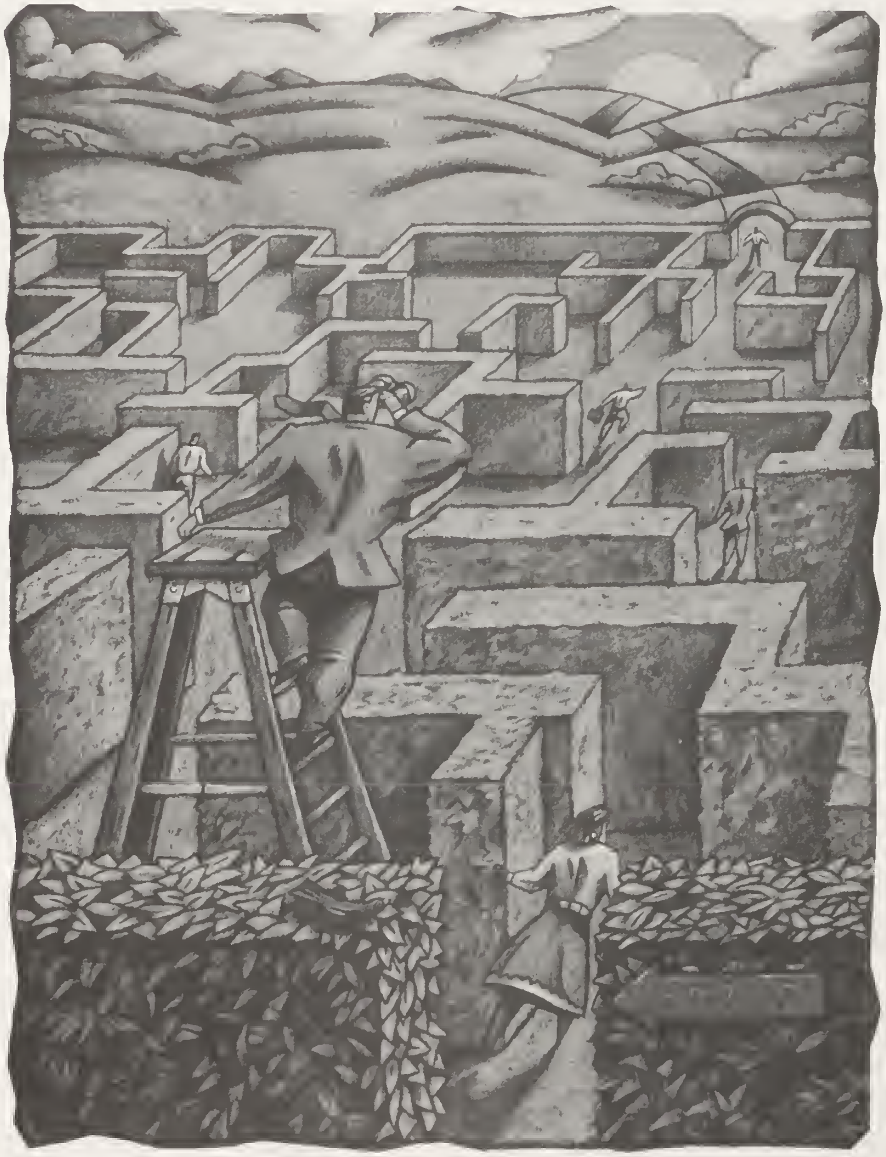

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MSMA Policies

Alcohol - Abuse

The MSMA continues to support the work of community-based organizations such as AA, Al-Anon, Narcotics Anonymous, and others, and it reaffirms its support of professional and public education efforts designed to alert people to the dangers of alcohol and drug abuse. In addition, the MSMA supports the Physicians' Health Program and similar programs aimed at helping the victims of alcohol and drug abuse to recover successfully. (1987)

Alcohol - Driving

The MSMA encourages a zero tolerance law (defined as blood alcohol of 0.02% or greater) for drivers under 21 years of age. Violation of this law would result in suspension or revocation of driver's license. (1996)

Blood Glucose Monitoring

The MSMA recognizes that a written prescription should be sufficient documentation for Medicaid patients to obtain a blood glucose meter every three years and blood glucose test strips as needed. (1997)

Board of Healing Arts

The MSMA opposes any legislation that would dilute the licensing power of the State Board of Registration for the Healing Arts to license physicians of good ethical and moral character. (1975)

The MSMA encourages and supports legislation directed toward developing a system of checks and balances with regard to the Board of Registration for the Healing Arts' ability to both investigate and assess (tax) physicians. (1992)

Reporting of Cancer

The MSMA supports efforts to require hospitals to report to the state all malignant neoplasms, with the exception of non-melanomatous cutaneous malignancies. These statistical data are necessary to determine relationships between cancer control efforts and the incidence of cancer in the state. (1982)

Collaborative Practice Guidelines

With the exception of extraordinary circumstances, the MSMA declares that a physician should not engage in a collaborative practice arrangement with more than two full-time equivalent advanced practice nurses and/or physician assistants at one time. Also a system of registration of all collaborative practice agreements, within sixty days of their execution, should be established. (1995)

Chelation Therapy

The MSMA supports the use of IV chelation therapy in FDA-approved applications only. (1990)

Chiropractic

The MSMA is unaware of any scientific evidence that proves that spinal manipulation and adjustment are appropriate treatments for such health conditions as hypertension, heart disease, stroke, cancer, diabetes, and infection. (1981)

DEA Numbers

The MSMA will work for legislation to outlaw the use of DEA numbers for non-controlled substances, the release of DEA number data to non-governmental entities, and the use of the numbers to track prescription histories of physicians for commercial use. (1997)

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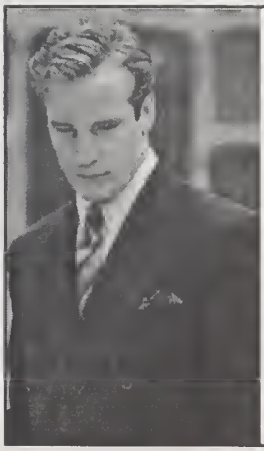

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Continued from page 375

Definition of Death

A person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he or she has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he or she has experienced a total and irreversible cessation of spontaneous brain functions, including the brain stem. Death shall have occurred at the time when the relevant functions ceased. (1987)

Ordering of Diagnostic Tests

With the exception of not-for-profit health fairs and mammography screening, the MSMA is opposed to, and considers unethical, the practice of ordering laboratory studies and other diagnostic tests without evidence or indication obtained by a physician in a history and physical examination. (1989; amended 1991)

Disabled

The MSMA is involved in seeking positive ways to encourage training and rehabilitation for disabled persons. The MSMA works with existing organizations to remove physical and emotional barriers that prevent people from working. (1982)

Drugs, Generic Prescribing

The MSMA opposes any interference into the practice of medicine by any governmental agency, third party payer, or commercial dispensing organization through mandated generic or therapeutic substitutions for physician prescriptions. (1992)

Drugs, Physician Dispensing

The MSMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with the AMA's published ethical guidelines. (1988)

The MSMA believes that dispensing of drugs and medical devices is part of the practice of medicine and that physicians always have the right to dispense needed drugs and devices. (1991)

Drugs, Therapeutic Substitution

The MSMA opposes the therapeutic substitution of prescribed medications. (1990)

Drunken Driving

The MSMA supports the development of local task forces to study and remedy the problem of drunken driving. These task forces should include physicians, prosecutors, law enforcement officers, and legislators. (1990)

Education, Loans for Medical Students

The MSMA supports continued federal and state subsidized, low-interest loan programs for medical students, with properly enforced repayment. (1982)

Education, School Health

Factual, academically founded courses should be developed and implemented by the Missouri Department of Education to teach human physiology and pathophysiology at the elementary and secondary levels of the school system. (1974)

County medical societies are urged to work with local school districts to assist in providing comprehensive health education programs, and the state colleges of Missouri are urged to prepare qualified health instructors trained to integrate health concepts into all the courses they teach. (1972)

Emergency Care

The MSMA supports the American College of Emergency Physicians and the American College of Surgeons standards for direct medical control of pre-hospital (emergency) care by qualified physicians. (1986)

ERISA

The MSMA supports federal legislation that would modify ERISA to hold self-insured, employee health benefits plans accountable for negligent utilization review decisions and ensure meaningful remedies and fair compensation to patients who are injured as a result of such a decision.

MSMA is in support of federal legislation that is developed to modify ERISA from retroactively changing health care benefits, including monetary policy limitations, after an employee has already contracted an illness or condition.

MSMA advocates that these ERISA modifications be included in federal health system reform. (1994)

Ethics, Education in Medical School

The MSMA supports the teaching of medical ethics to medical students and resident physicians, including information on the workings of professional disciplinary agencies. (1987)

Expert Witness Qualifications

The MSMA supports legislation to formalize required qualifications for physicians wishing to testify as expert witnesses. (1992)

Fee-For-Service Medicine

The MSMA believes that the traditional American fee-for-service medical system should be given equal consideration and equal treatment under the law as other systems of health care provision. (1990)

Fee Splitting

The MSMA reaffirms its support of the AMA Judicial Council's position that the acceptance of financial consideration in exchange for patient referrals, or fee splitting, is unethical and improper. (1985)

Fireworks

The MSMA supports legislation to prohibit the sale of Class C fire-works in the state of Missouri. (1991)

Fluoridation

The MSMA, realizing the medical importance of naturally occurring fluoride taken in proper concentration into the human body, recommends the addition of fluoride to all drinking water systems in Missouri in the concentration of one part per million. (1972)

Governmental Intrusion into Practice of Medicine

The MSMA opposes any further governmental intrusion into the practice of medicine, particularly in the form of rules and regulations from federal agencies. (1992)

Health Care Costs

The MSMA encourages individual physicians to do their part in helping moderate increases in health care costs by avoiding overutilization and by using restraint when considering fee increases, in order to keep them in line with general cost of practice increases. (1989)

Health Insurers

The MSMA will publish an annual expenditure summary of health care insurers. (1997)

Helmets, Use of

The MSMA urges all motorcyclists to wear protective head gear (helmets) to prevent death and disability. (1977)

The MSMA supports legislation requiring the use of bicycle safety helmets as an effective method of reducing death and injury. (1991)

Hemochromatosis

The MSMA encourages all physicians and health plans to include screening for hemochromatosis as part of routine preventive care and encourages the Missouri General Assembly to protect hemochromatosis patients and others with genetic disease from employment and insurance discrimination. (1997)

Continued on page 378

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Continued from page 377

Hospital Medical Staffs, Autonomy

Since the hospital medical staff is a largely autonomous entity within the hospital, the MSMA supports the securing of separate legal counsel by medical staff members when considering matters of rules, regulations and bylaws. (1985)

Hospital Medical Staffs, Membership

The hospital medical staff cannot be forced to accept for full voting membership any member of the allied health professions. This is in keeping with the MSMA's support of existing JCAHO and AMA guidelines that state no hospital governing board can unilaterally amend the bylaws of a self-governing medical staff, nor can it unreasonably withhold approval of the bylaws. (1987)

The MSMA supports existing state statutes and regulations that delineate requirements for hospital licensure and individual eligibility for medical staff privileges. (1989)

Human Rights

The MSMA continues to support the dignity of the individual, the importance of human rights and the sanctity of human life, and continues to oppose any discrimination based on an individual's ethnic origin, religious or political beliefs, or any such reprehensible policies. (1986)

Immunization

The MSMA supports American Academy of Pediatrics guidelines for immunization of children. (1987)

Indigent Care

The MSMA urges all physicians to share in the care of indigent patients. (1988)

Insurance, Insurance Company Communications

The MSMA urges health insurance companies to cease to communicate abusive and inappropriate language to patients regarding their physicians' fee structures and services. (1985)

Insurance, Maternity Coverage

The MSMA supports inclusion in all insurance policies for those in childbearing years of a clause providing complete maternity coverage.

In order to provide continuity of coverage, the following eligibility period should be written into all insurance policies concerning benefits for obstetric care: "A pregnancy which begins while the insurance is in force should be covered until the termination of the puerperium and until the newborn infant is discharged from the hospital to home care." (1974)

Insurance, New Waiting Periods

The MSMA believes employees should not have to undergo a new waiting period for coverage of preexisting illness whenever their employer changes insurance companies, particularly when the change is being made in the interest of controlling health care coverage costs. (1985)

Insurance, Psychiatric Illnesses

The MSMA recommends that the state require all health and accident insurance policies sold in Missouri to provide coverage for psychiatric illnesses equivalent to benefits for other medical and physical illnesses. (1978); Reaffirmed (1985)

Insurance, Right to Know

The MSMA encourages all third party payors to provide an easily understood explanation of their benefits and coverage to their policyholders. (1986)

International Medical Graduates

The MSMA Council and Committees are encouraged to consult with International Medical Graduate groups when subjects of interest come up. All physicians, international medical graduates included, are encouraged to participate in their component medical societies, the MSMA, and the AMA. (1982)

Licensing, Federal

The MSMA opposes any moves to require federal licensure of health manpower. (1976)

Mandated Second Opinion

The MSMA suggests that the physician who renders a mandated second opinion for a proposed surgical procedure not accept that person as a patient for the proposed surgical procedure. (1987)

Mandatory Assignment

The MSMA is opposed to mandatory assignment under Medicare. (1984)

The MSMA is opposed to the withholding of medical licensure based on the physician's nonacceptance of Medicare assignment. (1987)

Medical Examiner System

The establishment of a county medical examiner system as a replacement for the county coroner system is strongly recommended. (1971)

Medicare-Mandated Restrictions

The MSMA opposes Medicare-mandated restrictions on any laboratory tests, referrals, medical examinations or any financial arrangements that might be agreed upon between physician and patient. (1988)

Medicare - DRGs for Physician Reimbursement

The MSMA opposes the use of Diagnosis-Related Groups as a system of reimbursing physicians under the Medicare program. (1992)

Medicare - Reimbursement to Starting Physicians

The MSMA believes starting physicians should not be reimbursed at a lower rate than other physicians. All physicians should be reimbursed equally for equal services. (1992)

Medicare - Single Statewide Payment Factor

The MSMA supports the adoption by the Health Care Financing Administration of a single, statewide geographic Medicare physician payment adjustment factor for the state of Missouri. (1992)

Medicare - Third Party Reimbursement, Physicians

The MSMA supports equal reimbursement for equal professional services provided by a physician, regardless of his or her geographic location. (1982); Reaffirmed (1987)

Medicare - Reimbursement, Hospital DRGs

The MSMA believes it is unfair for Medicare to grant a lower payment to rural hospitals, as compared to urban hospitals, for patient care under the same DRG. (1988); Reaffirmed (1989)

Mentally Incompetent Patients, Hospitalization

The MSMA urges extension of the time limit from 7 to 21 days before the family of a mentally incompetent patient must petition the court for continuation of a hospitalization. (1985)

Mergers

The MSMA shall act as physicians' liaison with the state on matters of alliances of payors and providers, conversion of not-for-profit entities and mergers involving payors, insurers, and hospitals. (1997)

MSMF Loans

The Missouri State Medical Foundation requires membership in the Missouri State Medical Association for those medical students eligible for membership and receiving assistance from the Foundation. (1980)

Nurse Practitioners

The MSMA supports the doctrine that physicians should retain control of medical care and will challenge any person who is practicing medicine without a license, in the courts of law if necessary. (1978)

Patient Accountability

The MSMA encourages government, at all levels and whenever possible, to incorporate incentives for patients to behave in ways not detrimental to their health. (1992)

Peer Review Organization Data

The MSMA asks that data from the Missouri Patient Care Review Foundation concerning decision-making criteria for Medicare admission be made available to

Continued on page 380

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Continued from page 379

Missouri physicians as a way to ensure that denials are not having a negative impact on the quality of medical care for these patients. (1985)

The MSMA supports the current AMA program of data collection on the costs of PRO implementation and the inequities in the PRO system. (1987)

Peer Review Organization Review

The MSMA reaffirms its belief that physicians' work should be reviewed only by other physicians. In addition, the MSMA supports the modification of PRO standards of reviewer anonymity, believing that the reviewers' work should also be subject to review. (1990)

PHO Open Enrollment

The MSMA supports open enrollment of qualified physicians in their hospitals' PHOs in order to preserve physicians' right to participate in any health care plan operating in Missouri. (1994)

Physician as Patient Advocate

The MSMA affirms its support of the physician in the role of patient advocate in the consumption of health care services, particularly when this role conflicts with the economic goals of the physician's employing third party. (1987)

Physician, Right to Choose

The MSMA supports the right of each physician to determine for him or herself whom he or she will or will not accept as patients and to exercise his or her choice by the terms of contractual agreements with other physicians, medical groups, third party payers, governmental agencies, hospitals or other institutions. (1981; updated 1992)

Physician, Right to Hospital Privileges

The MSMA is opposed to the granting of hospital privileges to a physician based on that physician's profitability to the hospital. (1988)

Political Process

The Association encourages physicians to become Key Contacts, thereby increasing medicine's role in influencing actions taken by the Missouri General Assembly on issues of importance to our patients and our profession. (1983)

Primary Medical Care

Primary medical care shall be defined as only that care given by a licensed graduate of a medical or osteopathic school. (1977)

Referral to Licensed Limited Practitioner

A physician may refer a patient for diagnostic or therapeutic services to another physician, licensed limited practitioner, or any other licensed provider of health care services whenever the physician feels that these services will benefit the patient. As is the case with physician referrals, limited practitioner referrals should be based on the practitioner's individual competence and ability to perform service to the patient. (1981)

Registered Dietitians

The MSMA supports the concept that any person using the title "dietitian" should be a Registered Dietitian. (1987)

Health Care Decision-Making, Right to Refuse Treatment

Believing that critical decisions should be left to the patient, the family, or health care surrogate, and not to the state, the MSMA opposes any legislation that would require court approval for the withdrawal of life support systems, including artificial hydration and nutrition. The MSMA opposes legislation that would impose an arbitrary waiting period before such life support could be withdrawn. (1990)

Health Care Decision-Making, Surrogate Decision-Maker

The MSMA supports legislation allowing competent Missourians to appoint a health care surrogate, empowered by the patient to make medical decisions for him or her if he or she be unable. Such authority should include the power to accept or refuse any and all medical treatment for the patient, including artificial nutrition and hydration. (1990)

School Bus Safety

The MSMA endorses special pre-licensing examination and investigation of prospective school bus drivers in Missouri, according to criteria established by law. (1986)

Seatbelts

The MSMA supports primary enforcement of seatbelt laws and the prohibition of passengers in pickup truck open beds (1997)

Tobacco

The MSMA supports all laws governing tobacco sales, which includes all tobacco products, and that the sale of single cigarettes, sales of cigarettes from vending machines, and tobacco billboard advertising be banned.

MSMA supports the current law whereby the use of tobacco products by minors is illegal and that providers and minors breaking this law should face a fine for both providers and minors, and a revocation of licenses. An increased excise tax and licensure fee should be designated to fund existing local enforcement agencies activities related only to tobacco regulations and local communities should be allowed to establish and enforce local tobacco regulations even if stricter than state regulations. (1995)

The MSMA supports legislation directed at designating nonsmoking areas in public places, and prohibits smoking at all MSMA House of Delegates meetings and scientific sessions held in conjunction with these meetings. (1981)

The MSMA actively supports legislation prohibiting cigarette smoking in public indoor areas. (1983)

The MSMA should pursue an increase in the state tax on cigarettes to fund public education to counter the effects of tobacco advertising and encourage local governments to require retailers to purchase a license to sell tobacco. (1997)

Utilization Review, Reimbursement

In those hospitals that conduct utilization review of any inpatient care, compensation of physicians for such review is a legitimate expense. The cost of such review should be included in hospital rates and reimbursable costs regardless of the source of payment. (1976)

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- involves the **family** in designing a plan of care.
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- provides medications, medical supplies and equipment.
- provides education to prevent "crisis" situations, decrease family anxiety and prevent **unnecessary** hospitalizations.

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Constitution & Bylaws

(adopted 1903, revised April 1997)

Article I. Name of the Association

The name and title of this organization shall be the Missouri State Medical Association.

Article II. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

Article III. Membership

Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association.

Article IV. House of Delegates

The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past-Presidents of the Association, the Speaker and Vice-Speaker and the Deans of each medical school located in Missouri who are members of the Missouri State Medical Association, who shall serve as Delegates-at-Large. Its Secretary shall be the Secretary of the Missouri State Medical Association.

Article V. Council

The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, the duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physicians Section, and the Organized Medical Staff Section. A majority of voting members of the Council shall constitute a quorum.

Article VI. Council on Ethical and Judicial Affairs

The Council on Ethical and Judicial Affairs shall be the judicial body of the Association. It shall consist of five active members nominated by the President and elected by the House of Delegates.

Article VII. Sessions & Meetings

Section 1. The Association shall hold an annual Spring Convention of the House of Delegates, at places fixed by the House of Delegates, the time of which shall be fixed by the Council. During the Annual Convention, the House shall hold at least three sessions.

Section 2. Special meetings of the Association or the House of Delegates may be called by a two-thirds vote of the Council and shall be called upon a petition signed by members equal in number to one-third of the total number of delegates certified for the last Annual Convention.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and a Vice-Speaker of the House of Delegates, and Councilors selected as provided for.

Section 2. The Officers shall be elected annually. The term of Councilors and Vice-Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor and organized medical staff Councilor, who shall each be elected for a one-year term. Half of the membership of the Council shall be elected each year. The delegates from each Councilor District shall meet prior to the last day of the Annual Convention and elect the Councilors and Vice-Councilor from that district. The Delegates from the Medical Student Section, the Resident Physicians Section and the Organized Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor. In the event of death, resignation or removal of any Councilor, the Vice-Councilor shall automatically fill the vacancy. The Officers shall serve until their successors are elected and installed.

Article IX. Funds, Expenses and Budget

Funds shall be raised by a per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised in any other manner approved by the House of Delegates. The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

Article X. Referendum

At any General Meeting of the Association, it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Association for its vote. A majority vote of all members of the Association shall determine the question.

Petitions signed by 10 percent of the active members of the Association, including petitioners representing at least one-half of the component medical societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question.

Article XI. Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XII. Amendments

The House of Delegates may amend any article of the constitution by a two-thirds vote of the delegates present and voting in any Annual Convention, provided that such amendment shall have been published twice during the year in the Journal of the Association or sent officially to each component society at least two months prior to the meeting at which final action is to be taken.

Chapter I. Membership

Section 1. Members of this Association shall be those individuals whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri, except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine.

Section 2. No person who is under sentence of suspension or expulsion from any component society of this Association or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Association.

Section 3. There shall be five classes of members as follows:

Active members shall be limited to those members of component societies who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) if permitted by the bylaws of the component society, members who hold the degree of Doctor of Osteopathy, and (3) are entitled to exercise the rights of active membership in their component societies, as determined by their component societies, subject to the provisions of these Bylaws.

Resident members shall be limited to those members of the Resident Physicians Section who are serving a full-time postgraduate training program in a hospital approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Student members shall be limited to those members of the Medical Student Section who are pursuing a course of study leading to the degree of Doctor of Medicine in a medical school approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Honor members shall be limited to Honor members of component societies, which societies have requested that active members who have reached advanced years and have long served the Association and the profession be made Honor members of the Association. They shall enjoy all the privileges of active membership and shall be exempt from the payment of dues.

Special Dues-Exempt members shall be limited to those members of component societies who have been elected to the U.S. Congress, the Missouri State Legislature, or to an office in the executive branch of the state or federal government. They shall be exempt from the payment of dues until the term of their political office expires, and shall enjoy all the privileges of active membership.

Affiliate Members shall be those individuals who contribute to the health care of the public through employment service to MSMA members and component societies and who are not otherwise eligible for active membership. The criteria for affiliate membership and the policies governing the participation of affiliate members shall be established and maintained by the Council. Affiliate members shall have no voting rights nor will this class of membership apply toward House of Delegates or Council representation.

Chapter II. General Meetings

Section 1. The General Meetings shall be open to all registered members and guests.

Section 2. Any paper read before this Association shall be considered for publication in the Journal if the author so desires. Such papers may be given publication priority over regularly submitted papers but shall be subject to the same editorial review and selection policies.

Section 3. No person in the active practice of medicine in the State of Missouri shall appear on the program of the Association unless that person is a member of the Missouri State Medical Association or sponsored by a member. In the latter situation, the paper would be considered that presented by a member.

Chapter III. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Convention.

All resolutions received at the Association office no later than 45 days prior to the opening session of the Annual Convention will be accepted as business of the House of Delegates and will be published in the Delegate's Handbook. Any additional resolutions to be introduced at the opening session must be made available to each member of the House of Delegates at least 24 hours before the opening session. These will be accepted as business of the House at the opening session and will be referred to an appropriate Reference Committee. Resolutions introduced at the opening session, but which did not meet the 24-hour deadline, will be referred to a Reference Committee only if approved by two-thirds of the Delegates voting. Sufficient copies of the resolution, printed in standardized format, or funding for same, must be supplied by the individual or society introducing the resolution.

At the second session of the House of Delegates, introduction of Resolutions would be allowed only if approved by two-thirds of the delegates voting. The same procedure with regard to resolutions would be followed at the last session, but it would then take a unanimous vote of the House to allow such introduction. At the discretion of the Speaker, these conditions would not apply for resolutions of good wishes, condolences, congratulations and others of a personal nature.

Section 2. Delegates to the House of Delegates shall be allotted according to the following formula:

(a). Each component society shall be entitled to send each year one delegate or one alternate for each 25 full paid members or fraction thereof in the Association as of December 31 of the previous year.

(b). One additional delegate or alternate is allowed for each 100 members or major fraction thereof as of December 31 of the previous year.

(c). When a component society's full paid membership as of December 31 of the previous year reaches 1,000, that society shall be entitled to an additional 30 delegates or alternates.

(d). When a component society's full paid membership as of December 31 of the previous year reaches 2,000, that society shall be entitled to an additional 50 delegates or alternates.

(e). Each component society which is composed of two or more counties shall be entitled to at least one delegate from each of the counties having one or more member physicians practicing in the county of which the component society is composed; however, such delegates from multi-county component societies must practice or reside in the county they represent. Alternate delegates may be elected from the entire membership of the component medical societies.

(f). All Past-Presidents of the Association, the Speaker and Vice-Speaker, and the deans of each medical school located in Missouri who are members of the Missouri State Medical Association shall serve as Delegates-at-Large.

(g). Only duly elected delegates have the privilege of the floor at meetings of the House of Delegates. However, any delegate may request the privilege of the floor for any other individual, which privilege may be granted or denied by the Speaker, subject to disapproval by a majority vote of the House of Delegates.

Section 3. Each Medical School Component Society shall be entitled to send each year two delegates, elected by the component society, to represent the Medical Student Section in the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the component society. Such student delegates shall enjoy all the rights and privileges of all other delegates.

Section 4. The Resident Physicians Section shall be entitled to send each year six delegates elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association. Such resident delegates shall enjoy all rights and privileges of all other delegates.

Section 5. The Organized Medical Staff Section shall be entitled to send each year one delegate elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all rights and privileges of all other delegates.

Section 6. The International Medical Graduates Section shall be entitled to send each year one delegate and one alternate elected by the Section to the House of Delegates at the Annual Convention. Each delegate and alternate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all the rights and privileges of all other delegates.

Section 7. Forty delegates shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Association.

Section 8. From among members of the House of Delegates, the Speaker shall appoint reference committees to which reports and resolutions, on a majority vote of the House of Delegates, shall be referred as follows:

Reference Committee A
Reference Committee B
Reference Committee C
Reference Committee D
Reference Committee E

The Speaker may appoint such other reference committees as deemed necessary, upon approval of the House of Delegates.

The President shall appoint a Committee on Credentials.

Section 9. The House of Delegates shall elect delegates and alternates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 10. The House of Delegates shall divide the state into Councilor Districts, specifying which counties each district shall include and, when the best interest of the Association and the profession will be promoted thereby, organize in each a district medical society of which all members of the component societies shall be members.

Section 11. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate on their reports.

Section 12. The House of Delegates shall receive and act upon a complete detailed annual audit of receipts and expenses of the preceding year and a proposed budget for the current calendar year which shall have been prepared by the Council and submitted to the component societies at least four weeks prior to the Annual Convention. These shall be published in the Journal.

Section 13. The following shall be the general order of business of the House of Delegates for the first session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Report of officers.
6. Report of committees.
7. Unfinished business.
8. New business.

The following shall be the general order of business of the House of Delegates for the last session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Election of officers.
6. Reports of officers.
7. Reports of committees.
8. Unfinished business.
9. New business (Chap. III, Sec. 1).
10. Installation of officers.
11. President's appointments and installation of members to committees.
12. Selection of the place for the next Annual Convention.

At any session of the House of Delegates, the order of business may be changed by a two-thirds affirmative vote of the members present and voting.

Chapter IV. Election of Officers

Section 1. The President, on the first day of the Annual Convention, shall select a Committee on Nominations consisting of thirteen delegates, one from each Councilor District, one from the Medical Student Section, one from the Organized Medical Staff Section, one from the Resident Physicians Section, and one from the International Medical Graduates Section.

The Committee on Nominations shall determine that proposed candidates for office are qualified and willing to serve and shall report at the Second Session to the House of Delegates in the form of a ticket containing the names of one or more members for each of the officers listed in Article VIII of the Constitution, which are to be filled at the Annual Convention, excepting the Secretary and Treasurer, who are elected by the Council from the general membership.

Section 2. All contested elections shall be by written ballot. A majority of the votes cast shall be necessary to elect.

Delegates and Alternates for the American Medical Association shall be elected as follows:

The Nominating Committee shall propose one or more candidates for each delegate position for a full two-year term, one or more candidates for each alternate position for a full two-year term, and one or more names for each unexpired position.

When a nomination for AMA delegate term is contested, the AMA delegates shall be elected by ballot. Each MSMA delegate may have one vote for each delegate to be elected and each vote shall be cast for a different nominee. A nominee is elected if he/she receives votes on the majority of the ballots cast, and has the highest number of votes cast for that position. If all vacancies for AMA delegates are not filled on the first ballot, then subsequent ballots will be taken with the nominee receiving the fewest number of votes cast in each subsequent ballot dropping out of consideration on the next ballot and each MSMA delegate casting one vote for each position in each subsequent ballot until one nominee for each position is elected.

The election for AMA alternates and an election to fill an unexpired term will be conducted in the same manner.

In case no nominee for general offices of the Association (see Article VIII, Constitution) receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when that nominee shall be declared elected.

Section 3. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 4. Delegates present at the Annual Convention from Councilor Districts whose Councilors' and Vice-Councilor's terms expire shall hold meetings on or before the morning of the last day of the Annual Convention and elect Councilors and a Vice-Councilor for their district for a term of two years. The names of the elected Councilors and Vice-Councilors shall be given on prescribed forms to the Secretary for presentation to the House of Delegates. Each candidate for Councilor or Vice-Councilor must reside or practice in the district for which that candidate is elected.

Section 5. Each Councilor District shall be entitled to one Councilor for each 400 full paid members or portion thereof and full paid members of the Resident Physicians Section training in that Councilor District as of December 31 of the preceding year. Each District shall be entitled to one Vice-Councilor.

Section 6. Delegates from the Medical Student Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the medical student component societies shall serve on an annual renewable basis.

Section 7. Delegates from the Resident Physicians Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the Resident Physicians Section shall serve on an annual renewable basis.

Section 8. The Organized Medical Staff Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the Organized Medical Staff Section shall serve on an annual renewable basis.

Section 9. The International Medical Graduates Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the International Medical Graduates Section shall serve on a two-year renewable basis.

Section 10. The Speaker and Vice-Speaker shall not serve more than three consecutive terms.

Section 11. The Speaker shall appoint a parliamentarian to serve as such during the sessions of the House of Delegates at each Annual Convention and upon whom the Speaker may call before deciding points of order or procedure.

Chapter V. Duties of Officers

Section 1. The **President**, or a designated representative, shall preside at scientific sessions of the Association. The President shall preside at the House of Delegates in the absence of the Speaker or Vice-Speaker and until their successors are elected. The President shall appoint all committees not otherwise provided for. The President shall deliver an annual address at such times as may be arranged and shall perform such other duties as custom or parliamentary usage requires. The President shall be the real head of the profession of the state and assist the Councilors in building up the component societies and in making their work more practical and useful.

Section 2. The **President** and the **President-Elect** shall be members of the Council and shall attend all meetings of the Council. The President-Elect shall assume the office of the President at the Annual Convention following the election to the position of President-Elect. Should the office of President-Elect become vacant through death or otherwise, the Council may fill the vacancy by appointment until the next Annual Convention.

Section 3. The **Vice-Presidents** shall assist the President in the discharge of presidential duties. Prior to the meeting of the Nominating Committee, the President-Elect shall recommend to the Nominating Committee the name of a member to serve as First Vice-President. In the event of the death, resignation, or removal of the President, the First Vice-President shall serve as President for the unexpired term.

Section 4. The **Treasurer** shall give bond in the sum of $50,000. The Treasurer shall demand and receive all funds due the Association, together with bequests and donations. Money shall be paid out of the treasury only on the written order of the President and Executive Vice-President, the President and Treasurer, or the Treasurer and Executive Vice-President. The Treasurer shall subject the accounts to such examination as the House of Delegates may order, and shall annually render an account of treasury actions and of the state of the funds in his/her hands.

Section 5. The **Secretary** shall attend the General Meeting of the Association and the sessions of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He/She shall be Secretary of the Council and shall keep a record of its proceedings. The Secretary shall be the custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association that come into his/her hands. The Secretary shall provide for the registration of the members and delegates at the Annual Convention. The Secretary shall, with the cooperation of the secretaries of the component societies, keep a register of all the legal practitioners of the state by counties, noting on each the status in relation to the practitioner's component society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. The Secretary shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. The Secretary shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. The Secretary shall supply all component societies with the necessary blanks for making their reports and shall collect from them the regular per capita dues and assessments and turn the same over to the Treasurer.

Chapter VI. Council

Section 1. The Council shall meet during the Annual Convention and at such times as necessity may require, subject to the call of the Chair or on petition of three Councilors. It shall meet on the last day of the Annual Convention to organize. The Council shall elect a Chair and a Vice-Chair for a term of one year. The Chair may be reelected to serve not more than four consecutive terms of one year each. The Council shall, through its Chair, make an annual report to the House of Delegates.

Section 2. Each Councilor shall be organizer, peacemaker and censor for his/her district. The Councilor shall visit each county in the district at least once a year for the purpose of organizing component societies where none exists, for inquiring into the condition of the profession, and to keep in touch with the activities of and aid in the betterment of the component societies of the district. The Councilor shall make reports of the work and the condition of the profession of each county in that district to the Council. The necessary traveling expenses incurred by each Councilor in the line of duties herein imposed may be allowed on a properly itemized statement submitted monthly and within the current year, including the expense in attending the Annual Convention of the Association. No Councilor shall be eligible for the position of Delegate to the House of Delegates during his/her term of office as Councilor, nor shall a Councilor vote in the House of Delegates.

Section 3. The Council shall be the executive body of the Association and between the Annual Conventions shall exercise the power conferred on it by the House of Delegates under the Constitution and Bylaws.

Section 4. Charters shall be issued to component societies only on approval of the Council and shall be signed by the President and Secretary of this Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 5. In sparsely settled sections, the Council shall have authority to organize the members of two or more counties into societies, to be suitably designed so as to distinguish them from district societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 6. The Council shall provide for and supervise the issuance of all publications of the Association including proceedings, the transactions and memoirs, and shall have authority to appoint an Editor and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members, to be known as a Committee on Auditing and Appropriations, shall audit all accounts of this Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association for the following calendar year. This budget shall be prepared and presented for consideration in the last quarter of each year by the Committee on Auditing and Appropriations. A complete and detailed report shall be submitted to the component societies as provided in Chapter III, Section 11. The Council shall submit an annual report to the House of Delegates which shall specify the character and cost of the publications of the Association, the amount and character of all its property, and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Section 7. The Council shall appoint, at least six months prior to the Annual Convention, a committee consisting of three of its members to be known as the Committee on Arrangements for the Annual Convention. On recommendation of the Committee, the Council shall appoint a Chair of a Local Committee on Arrangements, who shall be a member of the component society of the county in which the Annual Convention is to be held, and who shall appoint and organize from the members of the component society the personnel of the Local Committee on Arrangements. The Local Committee on Arrangements shall serve as host for the Annual Convention and shall also act in an advisory capacity for the staff of the Executive Vice-President of the Association, who is responsible for arrangements for the Annual Convention.

Section 8. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Conventions of the House of Delegates; the appointee shall serve until the successor has been elected and has qualified.

Section 9. The salaries of all employees of the Association shall be fixed by the Council.

Section 10. The Council shall provide such headquarters for the Association as may be required to conduct its business properly.

Section 11. The Council shall be empowered to elect an Executive Vice-President and such other personnel as may be necessary, who need not be members of the Missouri State Medical Association, each of whom shall perform such duties as the Council may designate and receive such salary and serve for such periods and under such conditions as the Council may determine.

Chapter VII. Committees and Commissions

Section 1. Standing Committees of the Missouri State Medical Association, the Chairs of which shall be appointed by the Association President unless otherwise provided in these Bylaws, will be as follows:

Executive Committee.
Committee on Constitution and Bylaws.
Committee on Publication.
Committee on Legislative Affairs.
Committee on Planning.
Physicians Health Committee.
Young Physicians Committee

The **Executive Committee** shall consist of the Association President, the Immediate Past President, President-Elect, First Vice President, Secretary, Treasurer, Council Chair and Council Vice-Chair. The President of the Association shall be Chair of the Executive Committee. The Executive Committee shall plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Vice-President's Office between meetings of the Council, but shall be responsible at all times to the Council.

The Committee on **Constitution and Bylaws** shall consist of five members named by the President and shall propose such amendments to the Constitution and Bylaws as are deemed wise and expedient and bring before the House of Delegates such amendments as it or other members of the Association may present for consideration. The President shall appoint one member for one year, two members for two years and two members for three years. As the term of each expires, a successor shall be appointed for a term of three years.

The Committee on **Publication** shall consist of five members and be appointed annually by the Council and shall be responsible for general publication and distribution policies of the Journal. The editor of the Journal shall be designated by the Council and also shall serve as Chair of the Committee on Publication. The Editor shall be empowered to nominate an Editorial Board, subject to approval by the Council. The members of the Editorial Board will assist the Editor in soliciting, preparing and reviewing material for publication in the Journal.

The Committee on **Legislative Affairs** shall consist of five members of the Association, appointed annually by the President. The Committee shall consider legislative proposals affecting health problems of the people of the state and the practice of medicine and shall make recommendations to the Council and the House of Delegates as well as directing staff activities in such matters.

The **Planning Committee** shall consist of ten members to be appointed by the President. Two members shall be appointed for one year, two for two years, two for three years, two for four years and two for five years. As the term of each expires, a successor shall be appointed for a term of five years. In making such appointments, the President shall be governed by experience of the member, the size of the respective medical society and geographical area, so as to have a representative committee. Age of the members shall be considered to the end that one-third to one-half of the committee shall be of an age group that should contemplate ten to twenty years more of active practice.

The **Physicians Health Committee** shall consist of members of the Association appointed by the President for a term of three years. The Physicians Health Committee shall plan and execute programs of professional assistance for members of this Association who may require assistance to continue or return to their professional activities.

The **Young Physicians Committee** shall consist of members of the Association appointed by the President for a term of three years. The Young Physicians Committee shall act as a vehicle for increasing the involvement of young physicians in the membership activities of the Missouri State Medical Association.

Section 2. Standing Commissions of the Missouri State Medical Association, who shall be responsible to the Council and whose Chairs shall be appointed by the Association President, will be as follows:

Commission on Public Affairs.
Commission on Medical Economics,
  Third Party Medicine and Governmental
  Relations.
Commission on Continuing Education
  and Health Manpower.
Commission on Medical-Legal Affairs.
Commission on Interspecialty Medicine.

Subsec. a. The standing commissions, unless otherwise provided in these Bylaws, shall consist of fifteen members serving three-year terms and the terms will be staggered so that the President will appoint five members of each Commission each year. Initially, the President will appoint five members to one-year terms, five members to two-year terms and five members to three-year terms and no member shall serve more than two consecutive terms.

Subsec. b. The Chair of each Commission may appoint Ad Hoc Committees to carry out the Commission's programs. These Ad Hoc committees may include any Missouri State Medical Association member.

Subsec. c. The Chair of the Council shall appoint each year an appropriate Councilor to serve as advisor to each respective Commission.

The Commission on **Public Affairs** shall plan and execute programs designed to enhance the relationship between the public and the medical profession. The Commission shall have responsibility in the fields of industrial health, environmental health, medicine and religion, trauma, disaster medical care and national defense and other public matters.

The Commission on **Medical Economics, Third Party Medicine and Governmental Relations** shall keep close liaison and work with peer and utilization review mechanisms, insurance intermediaries and governmental agencies.

The Commission on **Continuing Education and Health Manpower** shall determine the character and scope of the scientific proceedings of the Association for each Annual Convention as well as to make all arrangements for such Annual Convention, subject to the instructions of the House of Delegates. The Commission shall also be responsible for the entire continuing education program of the Association, shall have all matters pertaining to hospitals referred to it, shall carry on all programs in the recruitment of health manpower in professional as well as in allied health fields and shall be responsible for programs in the rural health field.

The Commission on **Medical-Legal Affairs** shall investigate and study medical-legal matters affecting the practice of medicine, make recommendations to the Council and House of Delegates and also make certain that all Association members are kept informed of important developments in this field. The Commission also may work with similar groups formed by the State Bar Association on matters of joint interest and concern as well as with governmental and insurance agencies in this field.

The Commission on **Interspecialty Medicine** shall be composed of one representative of each statewide specialty group as recognized by the Association Council. The President of the Missouri State Medical Association shall appoint annually to the Commission a representative from each of the authorized groups as submitted to the President by the specialty organization. In the event that such a nominee is not submitted by an organization, the Association President may designate a member of the specialty group to serve on the Commission.

The Commission shall be charged with the responsibility of reviewing organization problems with respect to scientific programs, socioeconomic and legislative matters that affect their particular specialties; in addition, the Commission shall have the responsibility for programs and activities in fields relating to disease and health services involving the citizens of our state and such other matters as the Council shall direct. Also, the Commission shall provide close liaison between the various specialty organizations and the Missouri State Medical Association.

Section 3. Fifty percent of a Committee or a Commission should be present at an official meeting to constitute a quorum.

Section 4. Special committees may be appointed by the President or the Council as circumstances may demand.

Chapter VIII. Medical Student Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also students at an accredited medical school in the state of Missouri. The Section shall be the unifying body for the four independent Medical School Component Societies in the state.

Section 2. Governing Council. There shall be a Governing Council of the Medical Student Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members of the Governing Council. There shall be five voting members of the Governing Council, consisting of the officers, the Student Councilor and the Student Vice-Councilor.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d). Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Councilor and Vice-Councilor. The Councilor and Vice-Councilor shall be elected by the members of the respective Medical School Component Society. The following sequence shall be used in determining the Medical School Component Society from which the Councilor and Vice-Councilor shall be elected on an annual rotating basis: Washington University, St. Louis University, the University of Missouri-Kansas City, the University of Missouri-Columbia.

(f). Delegates. Each Medical School Component Society shall elect two Delegates to represent the Medical Student Section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Councilor and Vice-Councilor shall serve one-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Section Meeting. There shall be a meeting of members of the section held prior to each Annual Meeting of the MSMA House of Delegates.

Section 7. Representatives to the Section Meeting. The annual meeting of the Section shall be open to any member of the Medical Student Section.

Section 8. Purpose of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect a Chair, Vice Chair, and Secretary-Treasurer.

(e). To conduct such other business as may properly come before the meeting.

Chapter IX. Organized Medical Staff Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also members of a hospital medical staff in a Missouri hospital, and who are selected by the physician members of their respective medical staffs.

Section 2. Governing Council. There shall be a Governing Council of the Organized Medical Staff Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members. There shall be five voting members of the Governing Council, consisting of the officers, delegate and alternate delegate, elected at the business meeting of the section.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d). Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members of the section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Delegates and Alternate Delegate, shall serve two-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Business Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Section 7. Representatives to the Business Meeting. The physician members of the medical staff of each hospital may select a representative to the business meeting of the Organized Medical Staff Section. The representative must be an MSMA member who is an active voting member of the medical staff with clinical privileges at the hospital.

Representatives to the business meeting shall be elected by and from the active voting members of the medical staff of each hospital.

Representatives to the business meeting shall be properly certified by the President or Secretary of the medical staff.

Only duly selected representatives to the Organized Medical Staff Section shall have the right to vote at the business meeting of the section, but the meeting shall be open to any member of the MSMA. The meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council of the section and approved by the MSMA Council.

Section 8. Purposes of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect at the business meeting prior to the Annual Convention of the MSMA House of Delegates a Chair, Vice Chair, Secretary-Treasurer, Delegate and Alternate Delegate.

(e). To conduct such other business as may properly come before the meeting.

Chapter X. Resident Physicians Section

Section 1. Membership. The Resident Physicians Section shall be composed of Resident Members of the Missouri State Medical Association who are serving in approved training programs.

(a). Governing Council. There shall be a Governing Council for the Resident Physicians Section. The Governing Council shall consist of the officers of the Resident Physicians Section and two members-at-large of the Section. All members of the Governing Council must be Resident Physician members of the Missouri State Medical Association elected by the members attending the Business Meeting of the Resident Physicians Section.

1. Duties. The Governing Council shall direct the programs and the activities of the Resident Physicians Section.

2. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Resident Physicians Section.

Section 2. Officers. The Members attending the Business Meeting of the

Resident Physicians Section shall elect the following officers, who shall have these duties and responsibilities:

(a). Chair. The Chair shall preside at all meetings of the Governing Council and the Business Meetings of the Resident Physicians Section.

(b). Vice Chair. The Vice Chair shall preside at meetings of the Governing Council or the Business Meetings of the Resident Physicians Section, in the absence of the Chair or at the request of the Chair.

(c). Secretary. The Secretary shall maintain such records as are required or advisable for the conduct of the activities of the Resident Physician Section.

(d). Delegates and Alternate Delegates. The Delegates and Alternate Delegates shall represent the Section in the MSMA House of Delegates.

Section 3. Business Meeting. There shall be a Business Meeting of members of the Resident Physicians Section. The Business Meeting shall be held on a day prior to each Annual Meeting of the House of Delegates.

Section 4. Rules of Order. Only members of the Resident Physicians Section shall have the right to vote, but the meetings shall be open to any members of the Missouri State Medical Association. The meeting shall be conducted pursuant to established rules of procedure adopted by the Governing Council.

Section 5. Purposes of the Meeting. The Purpose of the meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To elect a Chair, who shall serve until the conclusion of the next Annual Meeting.

(c). To elect other officers of the Resident Physicians Section and two members-at-large of the Governing Council. Those elected shall assume office at the conclusion of the Annual Meeting at which they are elected and shall serve until the conclusion of the next Annual Meeting.

(d). To consider and vote upon such matters as may properly come before the meeting.

Chapter XI. International Medical Graduates Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also graduates of an international medical school.

Section 2. Governing Council. There shall be a Governing Council of the International Medical Graduates Section to direct the programs and activities of the section, subject to approval by the MSMA Council.

Section 3. Members. There shall be five voting members of the Governing Council, consisting of the officers, delegate, and alternate delegate, elected at the business meeting of the section.

Section 4. Officers. The officers of the section shall have the following duties and responsibilities:

(a). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(b). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair of at his/her request.

(c). Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(d). Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members in the MSMA House of Delegates.

Section 5. Term. Governing Council members, including the Delegate and Alternate Delegate, shall serve two-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 6. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Annual Meeting of the Section.

Section 7. Section Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Section 8. Representatives to the Section Meeting. The annual meeting of the Section shall be open to any member of the International Medical Graduates Section.

Section 9. Purpose of Section Meeting. The purpose of the Section Meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect at the section meeting prior to the Annual Convention of the MSMA House of Delegates a Chair, Vice Chair, Secretary-Treasurer, Delegate and Alternate Delegate.

(e). To conduct such other business as may properly come before the meeting.

Chapter XII. Dues and Assessments

Section 1. (a). The annual dues of this Association shall be $300, which shall be applicable to each active member of the Association beginning in 1987 and shall be levied per capita on the active members of the component societies; physicians leaving training programs and entering practice for the first time shall be assessed dues of $150 for the first calendar year and shall be Active members; physicians entering their second year of practice shall be assessed dues of $225 for the calendar year and shall be Active members; the per capita levy for resident members shall be $20 per year; student members shall be assessed dues of $5 per year; honor members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Those members who join after July 1 of any given year shall be assessed at one-half of their regular dues rate, outlined in this section, for the calendar year in which they join.

Section 2. Three dollars of the annual dues shall be credited to the account of the Journal for each member's annual subscription. The remainder of the amount shall be credited to the general fund of the Association.

Section 3. The House of Delegates may, when in its judgment the best interest of the Association demands, recommend an assessment on each active, resident and student member. Such assessment shall be levied only by consent of two-thirds of the members of the House of Delegates present and voting. Funds obtained from such special assessment shall be allocated only for the purposes for which such assessment is levied and in accordance with substantiating budgets. Unexpended balances from such assessments must be reported to the House of Delegates for reallocation.

Section 4. The Secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the per capita levies. Upon authorization of any component society, the Treasurer of this Association may collect the per capita levies directly from the members of that component society. Any member whose name has not been reported for enrollment and whose dues have not been remitted to the Treasurer of this Association on or before March 1 shall stand suspended until his/her name is properly reported and his/her dues for the current year are paid. On December 31 of each year, members delinquent in payment of dues, and assessment if such has been made, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an Annual Convention.

Chapter XIII. Rules of Conduct

Section 1. The ethical principle governing the members of the American Medical Association shall govern members of this Association.

Section 2. Any member of this Association who testifies as a medical expert witness outside of the specialty of the physician represents unethical conduct. In the future, any physician who testifies as a medical expert witness outside of his/her specialty or logical extension of his/her field of expertise or who interferes with the proper administration of justice by misrepresenting his/her qualifications or giving false or misleading testimony will be subject to expulsion, censorship, or reprimand after due process from the Missouri State Medical Association.

Any member of this Association who testifies as a medical expert witness without meeting the qualifications set forth in this section, shall be subject to expulsion, censorship, or reprimand after a due process hearing as set forth. An expert witness must have basic educational and professional knowledge as a general foundation for his/her testimony and, in addition, have current personal experience and practical familiarity with the problems being considered and be actively engaged in the practice of the medical subject under discussion.

Nothing in the above is to be construed as preventing the treating physician from testifying on the merits of the case.

Chapter XIV. Rules of Order

The deliberations of this Association shall be conducted in accordance with usages as defined in *Davis' Rules of Order*.

Chapter XV. Component Societies

Section 1. All component societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Association provided that their Constitutions and Bylaws shall have been submitted to the Council and received its approval.

Section 2. Each component society shall be judge of the qualifications of its members, subject to review and final decision by the Council on Ethical and Judicial Affairs of the State Association. Every reputable and legally qualified physician or medical student who does not practice, nor profess to practice sectarian medicine, and who resides or practices in the same county, who shall apply for membership on the prescribed form and subscribe for the Journal and pay the annual dues and assessments for the current year, shall be eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council on Ethical and Judicial Affairs of the State Association shall have final authority to expel a member should a component society fail to do so after being so requested by the Council on Ethical and Judicial Affairs.

The Council, may upon request of a component society, remit the state dues and assessment of a member who has become totally and permanently incapacitated through mental or physical disability and has been a member in good standing during the three consecutive years immediately preceding the disability; provided that the component society shall remit the component society dues of such member.

The Council may, upon request of a component society, remit the state dues and assessments of a deserving member found to fall within what is classified as a hardship case, during the period of said hardship until such time as the dues again become payable; provided that the component society shall remit the component society dues of such member.

A physician living near a component society boundary line may hold membership in that component society most convenient for the physician to attend, on permission of the component society in whose jurisdiction the physician resides.

Section 3. Any member who may feel aggrieved by the action of the component society in suspending or expelling him/her shall have the right to appeal to the Council on Ethical and Judicial Affairs, whose decision shall be final. A component society shall at all times be permitted to appeal or refer questions involving membership to the Council on Ethical and Judicial Affairs of the State Association for final determination.

Section 4. In hearing appeals, the Council on Ethical and Judicial Affairs may admit oral or written evidence or both as in its judgment will most fairly present the facts.

Section 5. When a member in good standing in a component society moves to another jurisdiction in this state, the member shall be given a written certificate of these facts by the secretary of the society, without cost, for transmission to the secretary of the society in the jurisdiction to which he/she moves. Pending the acceptance or rejection by the component society to which the physician moves, such member shall be considered to be in good standing in the component society from which he/she was certified and in the State Association to the end of the period for which dues have been paid.

A member of a component society who moves to and engages in the practice of medicine at a location in another area in which there is a component society shall forfeit membership in this Association and the Secretary shall remove the member's name from the roster of members of the Missouri State Medical Association unless within one year after such change of residence he/she becomes a member of the component society of the area to which he/she has moved.

Section 6. Each component society shall have general direction of the affairs of the profession in its area and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician and medical student in the area. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician and medical student in the area.

Section 7. At some meeting in advance of the Annual Convention of this Association, each component society, the Organized Medical Staff Section, the Medical Student Section, the Resident Physicians Section, and the International Medical Graduates Section shall elect one or more delegates and an equal number of alternates to represent it in the House of Delegates of this Association, in accordance with Chapter III, Section 2, 3, 4, or 5 of these Bylaws. The Secretary of each component society, the Organized Medical Staff Section, the Medical Student Section, the Resident Physicians Section, and the International Medical Graduates Section shall send a list of such delegates and alternates to the Secretary of this Association at least sixty days before the Annual Convention. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

Section 8. The secretary of each component society shall keep a roster of its members and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by the Council. He/She shall send a copy of the program of each meeting to the district Councilor and to the Secretary of the State Association.

Section 9. Any component society, in a manner approved by the State Association, or the State Association with the consent of the component society affected, may undertake, organize and put into effect plans for the medical care of indigent persons or indigent groups, and low-income groups, by agreements with physicians, public officials or others and by the use of contributions, cooperative funds or other means; provided, however, that a free choice of the available and participating physicians in that territory shall be allowed to the patient and that all relationships shall be and remain as though it were strictly an individual employment.

Chapter XVI. Council on Ethical and Judicial Affairs

Section 1. The Council on Ethical and Judicial Affairs shall have original jurisdiction in all questions involving Missouri State Medical Association membership, all controversies arising under the Constitution and Bylaws and under the rules of conduct as outlined in the Bylaws, and controversies between two or more component societies or their members. The Council on Ethical and Judicial Affairs shall be the judicial authority of the Missouri State Medical Association and its decisions shall be final. The Council on Ethical and Judicial Affairs shall also investigate general ethical conditions and matters pertaining to the relations of physicians to one another or to the public and make recommendations to the House of Delegates or the component societies.

Section 2. The Council on Ethical and Judicial Affairs shall be composed of five members elected to five-year terms. Nominees shall be submitted by the President for election by the House of Delegates. Any vacancy occurring on the Council on Ethical and Judicial Affairs shall be filled by nomination of the President and election by the House at its next Convention for the remainder of the unexpired term. The first five members of the Council on Ethical and Judicial Affairs shall be elected on a staggered basis; one for one year, one for two years, one for three years, one for four years, and one for five years.

Section 3. The Council on Ethical and Judicial Affairs shall select a Chair and Vice Chair and it may adopt such rules and regulations as it deems necessary and appropriate for the conduct of its affairs, subject to approval by the Missouri State Medical Association Council.

Chapter XVII. Amendments

Section 1. These Bylaws may be amended at any Annual Convention by a two-thirds vote of the delegates present and voting at that session, if the proposed amendment has been properly submitted to the House of Delegates and has lain on the table for one day.

Section 2. Upon the adoption of this Constitution and these Bylaws, all previous constitutions and bylaws are thereby repealed.

Chapter XVIII. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

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Norman P. Knowlton, III, MD, *Springfield*
Edmond Cabbabe, MD, *St. Louis*
Phillip Hornbostel, MD, *Sedalia*
William Dorzab, MD, *Raytown*
Gordon M. Goldman, MD, *St. Louis*

Council on Ethical and Judicial Affairs

	Term Expires
Frederick Hahn, Jr., MD, *Independence*	*2002*
Eugene Hansbrough, MD, *Poplar Bluff*	*2000*
*Hugh Stephenson, Jr., MD, *Columbia*	*1999*
Thomas Cooper, MD, *Farmington*	*1998*

Committee on Legislative Affairs

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William Dorzab, MD, *Raytown*
Mark Kasten, MD, *Chaffee*
*Robert Miller, MD, *St. Louis*
Daniel O'Sullivan, MD, *St. Louis*
Mrs. Jean Wankum, *Jefferson City*
Carol Williams, MD, *St. Louis*
Richard Butin, MD, *Kansas City*
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Mrs. Becky Moore, *Joplin*
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Robert Wankum, MD, *Jefferson City*
A.J. Campbell, MD, *Sedalia*
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David Wilkinson, MD, *St. Louis*

Committee on Constitution and Bylaws

	Term Expires
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Lawrence Lampton, MD, *Columbia*	*2000*
Sheila Shah, MD, *St. Joseph*	*1999*
Jean Chapman, MD, *Cape Girardeau*	*1999*
*Donald Potts, MD, *Kansas City*	*1998*

Commission on Continuing Education and Health Manpower

	Term Expires
Gerald Duling, MD, *St. Charles*	*2000*
David Glover, MD, *Warrensburg*	*2000*
Robert Schaaf, MD, *St. Joseph*	*2000*
Richard Heimburger, MD, *Osage Beach*	*2000*
Orin Trentham, III, MD, *Joplin*	*2000*
J. David Auner, MD, *Ironton*	*1999*
David Fleming, MD, *Moberly*	*1999*
J. Thomas Critchlow, MD, *Cape Girardeau*	*1999*
George Trimble, MD, *Kansas City*	*1999*
*David Martin, MD, *Chesterfield*	*1999*
William Larsen, MD, *Shawnee Mission, KS*	*1998*
Mark McClung, MD, *Kansas City*	*1998*
Aly Mohsen, MD, *Springfield*	*1998*

Commission on Interspecialty Medicine

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Missouri State Allergy Association
Michael Szewczyk, MD, *Columbia*
American College of Emergency Physicians, MO Chapter
Joe Hanaway, MD, *St. Louis*
Missouri State Neurological Association
Michael Korenfeld, MD, *Washington*
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Missouri Association of Plastic & Reconstructive Surgery
Michael Bukstein, MD, *Hannibal*
American College of Surgeons, MO Chapter
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Missouri Urological Society
Henry Macler, Jr., MD, *Hazelwood*
Missouri Society of Anesthesiologists
*Mark Martin, MD, *Lee's Summit*
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David Jimenez, MD, *Columbia*
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Missouri Psychiatric Association
Robert Churchill, MD, *Columbia*
Missouri Radiological Society
George Hruza, MD, *St. Louis*
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American College of OB-GYN, MO Sect.
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Dennis R. Pyszczynski, MD, *Kansas City*
Missouri Thoracic Society

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	Term Expires
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Sam Page, MD, *St.Louis*	*2000*
James Rogers, MD, *Springfield*	*2000*
Jeffrey Copeland, MD, *St. Charles*	*2000*
Richard Biery, MD, *Kansas City*	*2000*
Emil Miskovsky, MD, *St. Louis*	*1999*
Don Cole, MD, *Springfield*	*1999*
Steve Buie, MD, *Kansas City*	*1999*
*Phillip Hornbostel, MD, *Sedalia*	*1999*
Richard Gutknecht, MD, *Independence*	*1999*
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Ronald Riner, MD, *St. Louis*	*1998*
Michael Bukstein, MD, *Hannibal*	*1998*
William Stricker, MD, *Jefferson City*	*1998*
Timothy McIntire, MD, *Jefferson City*	*1998*

Commission on Medical-Legal Affairs

	Term Expires
Kenneth Bennett, MD, *St. Louis*	*2000*
Joseph Corrado, MD, *Mexico*	*2000*
William Snidle, MD, *Crystal City*	*2000*
Gus Wetzel, MD, *Clinton*	*2000*
James Conant, MD, *St. Joseph*	*2000*
Grant Bever, MD, *St. Louis*	*1999*
Howard Braby, MD, *Independence*	*1999*
Gregory Branham, MD, *St. Louis*	*1999*
Ronald Morley, DO, *Jefferson City*	*1999*
James Criscione, Jr., MD, *St. Louis*	*1999*
Edmond Cabbabe, MD, *St. Louis*	*1998*
Darrell Domann, MD, *Springfield*	*1998*
Roger Francis, MD, *Linn Creek*	*1998*
Ted Groshong, MD, *Columbia*	*1998*
*Marc Toarmina, MD, *Independence*	*1998*

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	Term Expires
Jo-Ellyn Ryall, MD, *St. Louis*	*2000*
Randall Huss, MD, *Rolla*	*2000*
John Lyskowski, MD, *Jefferson City*	*1999*
Thomas Cochran, MD, *Springfield*	*1999*
Charles Sincox, MD, *Washington*	*1999*
Michael Freeman, MD, *Cape Girardeau*	*1999*
*Thomas Anderson, MD, *Columbia*	*1998*
Donald McIntosh, MD, *Lee's Summit*	*1998*
K. Lynn Moritz, MD, *St. Louis*	*1998*

Committee on Planning

	Term Expires
William Turner, MD, *Nevada*	*2002*
Ronald Phillips, MD, *Kirksville*	*2002*
Laureano Mayuga, MD, *Cabool*	*2001*
Robert Zahn, MD, *Springfield*	*2001*
Stephen McCray, MD, *N. Kansas City*	*2000*
*Herluf G. Lund, Jr., MD, *Chesterfield*	*2000*
Roy Michael, DO, *Jefferson City*	*1999*
Nancy Weber-Borenstein, MD, *Cape Girardeau*	*1999*
Michael Curry, MD, *St. Charles*	*1998*
James Stewart, MD, *Weatherby Lake*	*1998*

Commission on Public Affairs

	Term Expires
James Blaine, MD, *Springfield*	*2000*
William Kapp, MD, *Cape Girardeau*	*2000*
Warren Lovinger, MD, *Nevada*	*2000*
K. Lynn Moritz, MD, *St. Louis*	*2000*
Don Coonce, MD, *Cape Girardeau*	*2000*
Jennifer Ashby, MD, *N. Kansas City*	*1999*
Nancy Bunge, MD, *Mexico*	*1999*
Ronnie Brownsworth, MD, *Springfield*	*1999*
Suzanne Miller, MD, *Grover*	*1999*
Michael Szewczyk, MD, *Columbia*	*1999*
Diane Brukardt, MD, *Columbia*	*1998*
Steve Halpin, MD, *Hannibal*	*1998*
Ravi Mehra, MD, *St. Louis*	*1998*
W. Mike See, MD, *Columbia*	*1998*
*Ann Peick, MD, *Poplar Bluff*	*1998*

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Tel. 816-299-8800

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Treasurer: Terry Klingele, MD
Contact: Kathy Cooper
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3990 N. Illinois
Belleville, IL 62226

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Contact: Gerard "Jay" Harms, Jr., Exec. Dir.
Missouri State Medical Association
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Jefferson City, MO 65102 1028
Tel. 573-636-5151; Fax 573-636-8552

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505 Couch Ave., #25
St. Louis, MO 63122

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E-Mail: jan@mmms.org

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Parkville, MO 64152
Tel. 816-741-8404

Mid-Missouri Pathology Society
Contact: Mitchell Rosenholtz, MD
UMC School of Medicine
Dept. PTH
Columbia, MO 65212
Tel. 573-882-1228; Fax 573-884-4612

Kansas City Society of Pathologists
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UMKC School of Dentistry
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Kansas City, MO 64108
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Overland Park, KS 66210

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Treasurer: Wagih A. Bari, MD
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Tel. 314-569-6120

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Tel. 573-447-3627; Fax 573-447-1112
E-Mail: jan@mmms.org

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Contact: Marlena D. Hickerson, Exec. Dir.
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Tel. 816-531-8432; Fax 816-531-8438

St. Louis Pediatric Society
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Chesterfield, MO 63017
Tel. 314-579-9919

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501 Rusk Rehabilitation Ctr., Dept. PM
Columbia, MO 65212
Tel. 314-882-3101

St. Louis Society of Physical Medicine & Rehabilitation
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SSM Rehabilitation Inst.
6420 Clayton Rd., 6th Fl.
St. Louis, MO 63117
Tel. 314-768-5230

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300 S. Mt. Auburn, #100
Cape Girardeau, MO 63703-8399
Tel. 573-651-4488; Fax 573-651-4431

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Sutherland Institute, Dept. PS
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Kansas City, KS 66160 7389

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Tel. 314-878-7770

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Contact: Tim Mastin, Program Coordinator
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Eastern Missouri Psychiatric Society
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Washington University Medical School
Dept. P
4940 Children's Place
St. Louis, MO 63110
Tel. 314-747-2013; Fax 314-747-2140

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Contact: Jan Frank, Exec. Dir.
310 Tiger Lane, #1
Columbia, MO 65203
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E-Mail: jan@mmms. org

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Contact: Metro. Med. of Greater K.C.
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Kansas City, MO 64108
Tel. 816-361-1771

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St. Joseph Hlth. Ctr.
330 1st Capitol Dr.
St. Charles, MO 63301

Greater Kansas City Radiological Society
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Truman Medical Ctr., Dept. R
2301 Holmes
Kansas City, MO 64108

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St. John's Mercy Hosp.
615 S. New Ballas Rd.
St. Louis, MO 63141
Tel. 314-569-6865; Fax 314-569-6863

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Washington University Medical School
Dept. RHU
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St. Louis, MO 63110

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Hlth. Sci. Ctr.
1 Hosp. Dr., #NW 301
Columbia, MO 65212
Tel. 573-882-6135
Contact: Ms. Linda Wheelen, Chapter Adm.
PO Box 4562
Springfield, MO 65808
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Contact: Ron Ellison, Exec. Dir.
113 Madison St., P.O. Box 1028
Jefferson City, MO 65102 1028
Tel. 573-636-5151; Fax 573-636-8552

Kansas City Surgical Society
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2401 Gillham Rd.
Kansas City, MO 64108
Tel. 816-234-3578; Fax 816-234-3821
Contact: Kathy Smith
2401 Gillham Rd.
Kansas City, MO 64108
Tel. 816-234-3578; Fax 816-234-3821

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St. Louis, MO 63141
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St. Louis, MO 63141
Tel. 314-569-6655

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- ▨ Andrew (010)
- ▨ Northwest (158)
- ▨ Grand River (078)
- ▨ Buchanan (030)
- ▨ Clinton (054)
- ▨ Clay-Platte (050)

District 2

- ▨ North Central (148)
- ▨ Northeast (150)
- ▨ Chariton-Macon-Monroe-Randolph (046)

District 5

- ▨ Audrain (014)
- ▨ Boone (Howard, Cooper) (026)
- ▨ Callaway (038)
- ▨ Montgomery (146)
- ▨ Cole (Moniteau, Osage) (058)
- ▨ Lake of the Ozarks (120)

District 4

- ▨ St. Charles-Lincoln (189)
- ▨ Franklin-Gasconade-Warren (074)

District 3

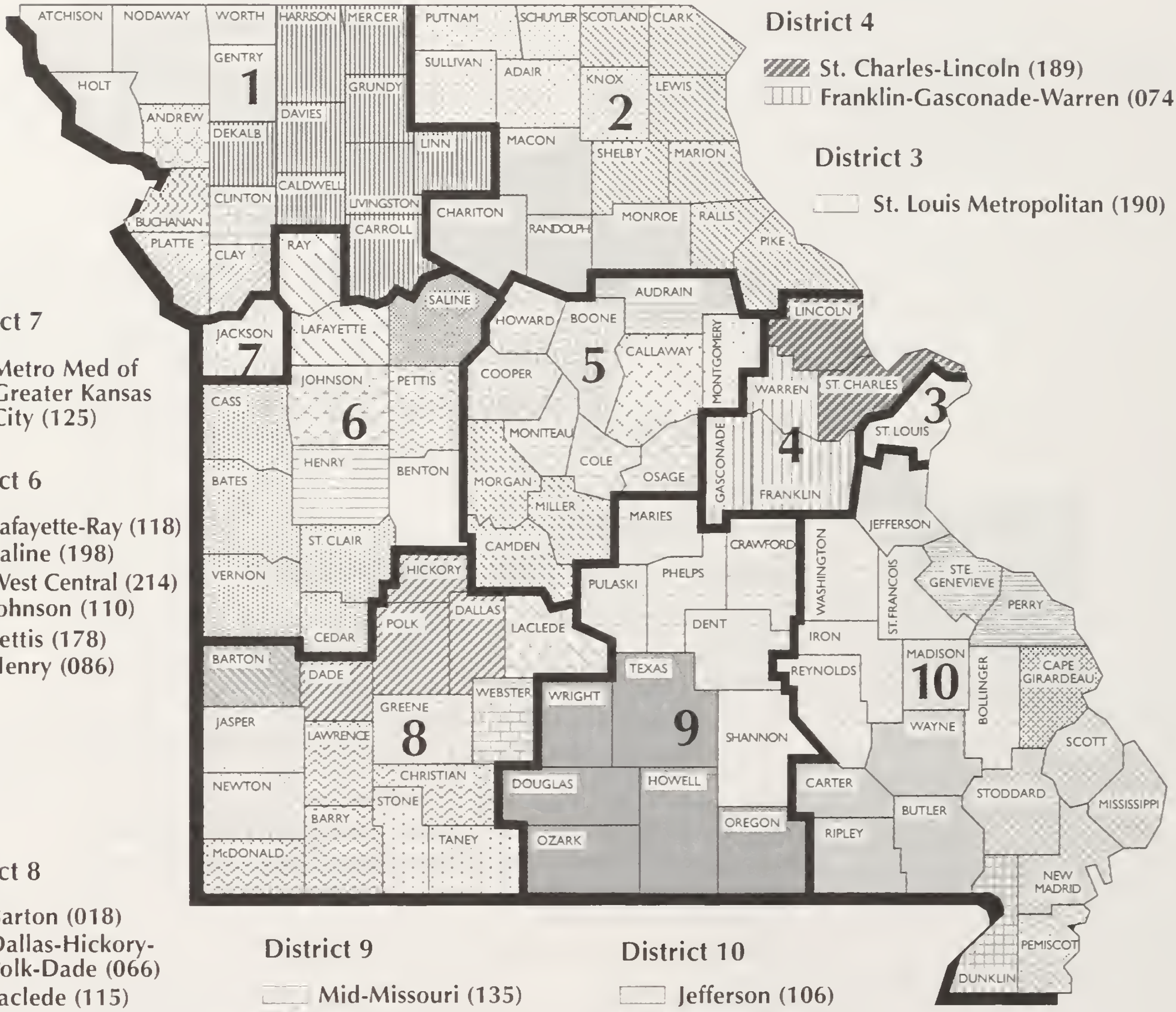
- ▨ St. Louis Metropolitan (190)

District 7

- ▨ Metro Med of Greater Kansas City (125)

District 6

- ▨ Lafayette-Ray (118)
- ▨ Saline (198)
- ▨ West Central (214)
- ▨ Johnson (110)
- ▨ Pettis (178)
- ▨ Henry (086)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CALLAWAY
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PETTIS
COOPER
5
WARREN
ST. CHARLES
3
CASS
6
MONITEAU
ST. LOUIS
4
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ST. CLAIR
CAMDEN
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HICKORY
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ST. FRANCOIS
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IRON
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REYNOLDS
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JASPER
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HOWELL
CARTER
STODDARD
MISSISSIPPI
STONE
BUTLER
BARRY
TANEY
OZARK
OREGON
RIPLEY
McDONALD
NEW MADRID
PEMISCOT
DUNKLIN

District 8

- ▨ Barton (018)
- ▨ Dallas-Hickory-Polk-Dade (066)
- ▨ Laclede (115)
- ▨ Jasper-Newton Metropolitan (102)
- ▨ Ozarks (166)
- ▨ Greene (082)
- ▨ Webster (210)
- ▨ Tri-Lakes (208)

District 9

- ▨ Mid-Missouri (135)
- ▨ South Central (206)

District 10

- ▨ Jefferson (106)
- ▨ Mineral Area (138)
- ▨ Perry-Ste. Genevieve (174)
- ▨ Cape Girardeau Area (042)
- ▨ Butler-Wayne-Ripley-Carter (034)
- ▨ SEMO (202)
- ▨ Dunklin (070)
- ▨ Pemiscot (170)

DISTRICT #1

Organized Medical Societies:
Andrew (010), Buchanan (030), Clinton (054), Northwest (158), Grand River (078), Clay-Platte (050)

Counties in District:
Andrew
Atchison
Buchanan
Caldwell
Carroll
Clay
Clinton
Davies
DeKalb
Gentry
Grundy
Harrison
Holt
Linn
Livingston
Mercer
Nodaway
Platte
Worth

DISTRICT #2

Organized Medical Societies:
Chariton-Macon-Monroe-Randolph (046)
North Central (148) Northeast (150)

Counties in District:
Adair
Chariton
Clark
Knox
Macon
Marion
Monroe
Lewis
Pike
Putnam
Ralls
Randolph
Schuyler
Scotland
Shelby
Sullivan

DISTRICT #3

Organized Medical Society:
St. Louis Metropolitan (190)

Areas in District: St. Louis City & St. Louis County

DISTRICT #4

Organized Medical Societies:
Franklin-Gasconade-Warren (074) *(Tri-County)*
St. Charles-Lincoln (189)

Counties in District
Franklin
Gasconade
Lincoln
Warren
St. Charles

DISTRICT #5

Organized Medical Societies:
Audrain (014), Boone (026) Callaway (038), Cole (058), Lake of the Ozarks (120), Montgomery (146)

Counties in District:
Audrain
Boone
Callaway
Camden
Cole
Cooper
Howard
Miller
Moniteau
Montgomery
Morgan
Osage

* no organized county medical society.

DISTRICT #6

Organized Medical Societies:
Henry (086), Johnson (110), Lafayette-Ray (118), Pettis (178), Saline (198), West Central (214)

Counties in District:
Bates
Benton*
Cass
Cedar
Henry
Johnson
Lafayette
Pettis
Saline
Ray
St. Clair
Vernon

DISTRICT #7

Organized Medical Society:
Metro Med Society of Greater Kansas City (125)
Areas in District: Kansas City & Jackson County

DISTRICT #8

Organized Medical Societies:
Barton (018), Dallas-Hickory-Polk-Dade (066) Greene (082), Jasper-Newton Metropolitan (102), Laclede (115), Ozarks (166), Tri-Lakes (208), Webster (210)

Counties in District:
Barry
Barton
Christian
Dade
Dallas
Greene
Hickory
Jasper
Lawrence
Laclede
McDonald
Newton
Polk
Stone
Taney
Webster

DISTRICT #9

Organized Medical Societies:
Mid-Missouri (135), South Central (206)

Counties in District:
Crawford
Dent
Douglas
Howell
Maries
Oregon
Ozark
Phelps
Pulaski
Shannon*
Texas
Wright

DISTRICT #10

Organized Medical Societies:
Butler-Wayne-Ripley-Carter (034), Cape Girardeau (042) Dunklin (070), Jefferson (106), Mineral Area (138), Pemiscot (170), Perry-Ste. Genevieve (174), SEMO (202)

Counties in District:
Bollinger
Butler
Cape Girardeau
Carter
Dunklin
Iron
Jefferson
Madison
Mississippi
New Madrid
Pemiscot
Perry
Reynolds
Ripley
St. Francois
Ste. Genevieve
Scott
Stoddard
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Wayne

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Savannah, MO 64485
816-324-3121

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573-581-7007

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Lamar, MO 65759 1743
417-682-5584

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573-447-3627

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Cape Girardeau, MO 63703
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Plattsburg, MO 64477 1424

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Wellsville, MO 63384 1616

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417-451-1234

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Ste. Genevieve, MO 63670
573-883-7424

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Sedalia, MO 65301 8121
816-826-5890

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573-817-0550

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038	Callaway
042	Cape Girardeau
046	Chariton-Macon-Monroe-Randolph
050	Clay-Platte
054	Clinton
058	Cole
066	Dallas-Hickory-Polk-Dade
070	Dunklin
074	Franklin-Gasconade-Warren
078	Grand River
082	Greene
085	Greene Residents
086	Henry
102	Jasper-Newton Metropolitan
106	Jefferson
110	Johnson
115	Laclede
118	Lafayette-Ray
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125	Metropolitan Medical Society of Greater Kansas City
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146	Montgomery
148	North Central
150	Northeast
158	Northwest
166	Ozarks
170	Pemiscot
174	Perry-Ste. Genevieve
178	Pettis
189	St. Charles-Lincoln
190	St. Louis Metropolitan
195	St. Louis Metropolitan Residents
198	Saline
202	SEMO
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A

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Abele, William A.	Boonville	026
Abella, Ben Zulueta	Belton	125
Abend, Melvin N.	Kansas City	125
Abercrombie, Keith	Kansas City	125
Abernathie, Dennis L.	Columbia	026
Abinoja, Conrado B.	St. Louis	190
Abodeely, Daniel A.	St. Louis	190
Abrams, Bernard M.	Kansas City	125
Abu Dalu, Ziad	St. Louis	190
Aceto, Thomas, Jr.	St. Louis	190
Acuff, R. Phillip	St. Joseph	030
Adams, Allen G.	St. Louis	190
Adams, Dawn	Independence	126
Adams, John G.	Cape Girardeau	042
Adams, Kenneth A.	Independence	125
Adams, Mark A.	Columbia	026
Adams, Riley R.	Cape Girardeau	042
Adams, Stephen R.	Springfield	082
Adams, Susan E.	St. Louis	190
Adelman, Arthur	Shawnee Mission, KS	125
Adelmann, Eugene	St. Louis	190
Adkins, Charlene	Columbia	026
***Adkison, Brian W.**	Seymour	082
Adler, Benard C.	St. Louis	190
Adler, Federico	Kansas City	125
Aeder, Mark I.	Kansas City	125
Aff-Drum, Helen	St. Louis	190
Afuwape, Emanuel A.	E. St Louis, IL	190
Aguinaldo, Jaime A.	St. Louis	190
Ahadi, Abd U.	St. Louis	190
Ahern, Archibald M.	St. Louis	190
Ahlering, George H.	St. Louis	190
Ahlum, Sandra J.	Hannibal	150
Ahlvin, Robert C.	Sikeston	202
Ahmad, Bashir	Pacific	190
Ahmad, Musaddeque	Potosi	138
Ahmad, Naseer	St. Louis	190
Ahmad, Nusrat J.	Chesterfield	190
Ahmad, Shahzad	Sikeston	202
Ahmann, Thomas M.	Mexico	014
Ahnemann, Janet L.	Clinton	086
Ahuja, Suraj P.	Kansas City	125
Ailor, Edgar I.	Columbia	026
Ailor, Susan K.	Columbia	026
Ajans, Zaki A.	Mexico	014
Akers, Joan E.	Kansas City	125
Akin, C. David	Independence	125
Akremi, Janet E.	Houston	206
Al-Aly, Robert M.	Chesterfield	190
Al-Shathir, Saad	Joplin	102
Alander, Dirk H.	Kansas City	125
Alaswad, Khaldoon	Kansas City	126
Alba, Laura M.	Kansas City	126
Albani, Frank J.	Liberty	050
Albanna, Faisal J.	St. Louis	190
Albano, Benjamin I.	Crystal City	106
Albano, Grace A.	Lee's Summit	125
Albera, Victor H.	St. Clair	190
Alberg, Marvin R.	Kansas City	125
Albert, I. Renee	St. Louis	190
Albracht, Renee M.	St. Louis	195
Albritton, Michael A.	Springfield	082
Albus, Thomas E.	Bridgeton	190
Alcancia, Elpidio Y.	Springfield	082
Aldasouqi, Saleh	Cape Girardeau	042
Alderman, Lillian C.	Liberty	050
Aldridge, George A.	Poplar Bluff	034
Alegre, Jorge M.	Chesterfield	190
Aleksander, Bernardo G.	El Paso, TX	190
Alex, Morris	St. Louis	190
Alexander, Susie	Kansas City	002
Alexander, Thomas	Mission, KS	126
Alfie, Salomon	Shawnee Mission, KS	125
Alias, Susy	St. Louis	190
Allain, James J.	Shawnee Mission, KS	050
Allan, James E.	Jefferson City	058
Allan, James R.	Columbia	026
Allcorn, Donald K.	Lincoln	178
Allego, Melquiadito M.	Perryville	174
Allen, Brent T.	St. Louis	190
Allen, David O.	Bella Vista, AR	102
Allen, James H.	St. Louis	190
Allen, Jerry H.	Springfield	082
Allen, Jerry H.	Washington	074
Allen, Mark J.	Kansas City	125
Allen, Melvin A.	St. Louis	190
Allen, Robert E.	Shawnee Mission, KS	125
Allen, Thomas P.	Overland Park, KS	125
Allen, William C.	Columbia	026
Allen, William Corwin	Columbia	026
Allison, James B.	Springfield	082
Allphin, Allan L.	Springfield	082
Allyn, Steven L.	Springfield	082
Almiron, Osias A.	House Springs	190
Almond, Toni	Columbia	026
Almuttar, Wasif F.	Maryville	158
Alonso-Yague, Pascual	Florissant	190
Alsarraj, MHD B.	Lenexa, KS	126
Alsop, Webb S, Jr.	Shawnee Mission, KS	125
Altenbernd, Todd W.	Cape Girardeau	042
Altepeter, H. Martin	St. Louis	190
Alvarez, Juan M.	St. Louis	190
Alvarez, Ulises C.	Florissant	190
Alyea, James O.	Columbia	026
Ames, Mary B.	Santa Cruz, CA	125
Amin, Avi	St. Louis	195
Amin, Navin J.	St. Louis	190
Amini, Jafar	Shawnee Mission, KS	125
Amjad, Mohammad T.	St. Louis	190
Ammala, Edward D.	Rolla	135
Amon, Erol	St. Louis	190
Ancheta, Apolinario A.	Springfield	082
Anderson, Charles B.	St. Louis	190
Anderson, D. Claire	St. Louis	190
Anderson, Daphne W.	Springfield	082
Anderson, David J.	St. Louis	190
Anderson, David R.	Cape Girardeau	042
Anderson, Frank K.	St. Charles	189
Anderson, Margaret R.	St. Peters	002
Anderson, Paul B.	Neosho	166
Anderson, Philip C.	Columbia	026
Anderson, Raymond B.	Shawnee Mission, KS	125
Anderson, Thomas R.	Columbia	026
Andres, Edward H.	St. Joseph	030
Andrews, Elizabeth J.	Springfield	082
***Andrews, Lynthia B.**	Lexington	030
Andrews, Paul E.	Springfield	082
Andrus, Bailey C.	Leawood, KS	125
Andrus, Charles H.	Westchester, IL	190
Anglen, Jeffrey O.	Columbia	026

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Anglo, Luis B.	190	St. Louis
Anglo, Luis J.	002	St. Louis
Anslinger, David L.	190	Chesterfield
Anstey, George C.	190	St. Ann
Anstey, John T.	190	St. Ann
Anthony, Dallas D.	082	Springfield
Anthony, James P.	125	Kansas City
Apostol, Andres G.	166	Monett
Appelbaum, John K.	002	St. Louis
Applegate, Clara	206	West Plains
Applewhite, Thomas A.	190	St. Louis
Apprill, Phillip G.	190	St. Louis
Apte, Sunil M.	074	Washington
Arbab, Ali A.	125	Kansas City
Arendt, Kathryn L.	190	St. Louis
Arenos, Proceso T.	190	St. Louis
Arias, Fernando	190	St. Louis
Arkin, Steven M.	125	Kansas City
Armbruster, A. A.	002	Stilwell, KS
Armstrong, Stephen D.	082	Springfield
Arney, William G.	190	St. Louis
Arnold, Donald E.	190	Ballwin
Arnold, John D.	125	Scottsdale, AZ
Arnold, Kenneth J.	190	Chesterfield
Arnold, Paul N.	082	Springfield
Aronberg, Jerome M.	190	St. Louis
Aronovitz, Joseph A.	195	St. Louis
Arora, Ravinder S.	178	Sedalia
Arribas, Neva P.	190	St. Louis
Arst, Herbert E.	050	Kansas City
Arthaud, J. B.	026	Rockport, MA
Arthur, Gerald L.	026	Columbia
Asel, Norman D.	026	Columbia
Ash, Charles J.	082	Springfield
Ashby, Jennifer D.	125	N. Kansas City
Ashcraft, Keith W.	125	Overland Park, KS
Asher, Irving	026	Columbia

***Asher, Kennett D.**	042	Jackson
Ashley, Lillard G., Jr.	125	Kansas City
Ashley, Michael E.	082	Springfield
Ashley, Thomas E.	082	Springfield
Askew, John H.	202	Sikeston
Atkinson, John P.	190	St. Louis
Atwell, Floyd C.	125	Shawnee Mission, KS
Atwood, Steven D.	082	Springfield
Aubuchon, Craig E.	190	St. Louis
Auer, Arthur I.	190	St. Louis
Aufderheide, G. Russell	190	St. Louis
Augustine, Amala Kumar D.	195	Valley Park
Auner, J. David	138	Ironton
Austin, George M.	125	Blue Springs
Avallone, Anthony N.	082	Springfield
Avery, David M.	082	Springfield
Avins, Laurence R.	190	St. Louis
Avioli, Louis V.	190	St. Louis
***Awad, Ahmed M.**	126	Kansas City
Awadalla, Sylvia	190	St. Louis
Axness, Mark E.	082	Springfield
Ayata, Sedat M.	190	Chesterfield
Aydt, Sarah A.	042	Cape Girardeau
Aylward, Howard J., Sr.	190	Santa Barbara, CA
Ayvazian, Vatche H.	190	St. Louis
Azan, Abraham N.	178	Sedalia
Azan, Kenneth N.	178	Sedalia
Azrak, Elie	195	Chesterfield

B

***Baade, Norman F.**	030	St. Joseph
Baak, Steven W.	190	St. Louis
Baber, William W.	190	St. Louis
Babka, Joseph J.	190	St. Louis
Bach, Lysle M.	150	Hannibal
Back, Donald K.	082	Springfield
Backer, Matt H., Jr.	190	San Diego, CA
Backer, Robert J.	190	St. Louis
Backstrom, Jay T.	125	Kansas City
***Bader, Larry W.**	026	Columbia
Bagby, Jack M., Jr.	082	Springfield
Baglan, Robert J.	190	St. Louis
Bagwe, Lata R.	190	St. Louis
Bahn, Charles F.	042	Prescott, AZ
Bai, Samuel S.	106	Festus
Bailey, Alan H.	082	Springfield
Bailey, Colin E.	026	Columbia
Bailey, Gregory J.	190	St. Louis
Bailey, Sean B.	190	St. Louis
Bailiff, Robert	082	Springfield
Baird, Keim L.	189	St. Charles
Baker, Carl N.	190	St. Louis
Baker, Donald L.	074	Union
Baker, John H.	190	Creve Coeur
Baker, Josephine D.	046	Moberly
Baker, Marion H.	058	Jefferson City
Baker, Philip J.	125	Lee's Summit
Baker, Sherwood	026	Columbia
Baker, Tim E.	074	Washington
***Balcer, Conrad S.**	058	Jefferson City
Baldwin, Richard, Jr.	190	St. Louis
Baldwin, Theodore R.	118	Excelsior Springs
Bale, Robert D.	190	St. Louis
Balfe, Dennis M.	190	St. Louis
Ball, David A.	102	Joplin
Ballard, Betty	195	Fenton
Ballinger, Walter F.	190	St. Louis
Balster, Vernon H.	190	St. Louis
Banchs, Jose	195	St. Louis
Bandle, Donald F.	190	St. Louis
Banerjee, Dilip	074	Washington
Banton, M. Roman	190	St. Louis
Banton, Thomas J., Jr.	190	St. Louis
Banton, William C., II	190	St. Louis
Barbe, David O.	206	Mountain Grove

Barbee, Charles W.	026	Columbia
Barber, Gregory B.	125	Kansas City
Barbieri, Craig D.	126	Kansas City
Barbour, Marvin R.	034	Poplar Bluff
Bardsley, John L.	190	St. Louis
Bare, Chester I., Jr.	125	Raytown
Bare, Edward F.	158	Tarkio
Bareis, Robert J.	210	Marshfield
Barelli, Pat A.	125	Leawood, KS
Bari, Wagih A.	190	St. Louis
Barjenbruch, Peggy W.	014	Mexico
Barker, Edward T.	190	St. Louis
Barloon, James H.	125	Shawnee Mission, KS
Barnard, John L., Jr.	125	Kansas City
Barnes, Charles H.	125	Kansas City
Barnes, Larry G.	166	Neosho
Barnett, Floyd A.	046	Paris
Barnhill, Floyd R.	082	Springfield
Barnthouse, Cris D.	125	Kansas City
Barnthouse, Joseph R.	125	Kansas City
***Barnum, Grant M.**	120	Osage Beach
Barr, Glenn A.	125	Kansas City
Barr, W. Kent	125	N. Kansas City
Barragan, Hector D.	190	St. Louis
Barrett, Scott R., Sr.	190	Columbia, MD
Barrido, Lemuel T.	138	Potosi
***Barrow, Chelmer L., Jr.**	190	Lake St. Louis
Barrow, Jack	190	St. Louis
Barry, William B.	125	Kansas City
Bartell, Michael F.	190	St. Louis
Barter, Bruce	125	Leawood, KS
Bartlett, Hugh C.	135	Rolla
Bartley, Richard L.	082	Springfield
Barton, Premsri T.	190	St. Louis
***Bartow, John H.**	030	St. Joseph
Bartulica, Nicholas	030	St. Joseph
Bashyakarla, Rajeeva K.	102	Joplin

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Baskurt, Mehmet V.	**034**	Poplar Bluff
Bass, Barry J.	**135**	Rolla
Bass, Walter R.	**125**	Prairie Village, KS
Bassiri, Haleh G.	**126**	Kansas City
Bassman, Donald R.	**190**	St. Louis
Batan-Co, Ruby L.	**190**	Chesterfield
Batchu, Sudhir S.	**026**	Columbia
Bateman, Timothy M.	**125**	Kansas City
Bates, G. Comer	**050**	Kansas City
Batrash, Ahmad	**126**	Merriam, KS
Batterson, James R., Jr.	**125**	Kansas City
Batts, Barbara A.	**125**	Kansas City
Batty, Thomas V.	**214**	Eldorado Springs
Baudendistel, Lawrence J.	**190**	St. Louis
Bauer, Daniel J.	**190**	St. Louis
Bauer, Lafe W.	**125**	Overland Park, KS
Baughman, Lori C.	**126**	Gladstone
Baula, Armindo G.	**190**	St. Louis
Bauman, Alan E.	**125**	Kansas City
Baumann, Albert R.	**135**	Steelville
Baumann, Daniel J.	**190**	St. Louis
Bauschard, Frederick D.	**190**	St. Louis
Bautista, Joel O.	**046**	Moberly
Bautista, Rogelio L.	**046**	Moberly
Bautz, James B.	**125**	Kansas City
Bauwens, Daniel B.	**190**	Chesterfield
Bavlsik, Michael D.	**002**	St. Louis
Bayer, William L.	**125**	Kansas City
Beal, Catherine E.	**190**	St. Louis
Beall, McPherson S., Jr.	**125**	Kansas City
Beardman, Todd	**126**	Kansas City
Beare, Lucia V.	**190**	St. Louis
Beasey, Matthew D.	**126**	Shawnee Mission, KS
Beato, David L.	**190**	St. Louis
Beaty, William R.	**190**	St. Ann
Beauchamp, Gary D.	**125**	Shawnee Mission, KS
Beck, David A.	**026**	Columbia
Beck, Marcus R.	**026**	Columbia
Beck, Paul M.	**030**	St. Joseph
Becker, Bernard	**190**	St. Louis
Becker, Robert L.	**190**	St. Louis
Becker, Stanley C.	**190**	St. Louis
Becker, William L.	**190**	St. Louis
Beckett, Wm. Wilson	**026**	Columbia
Beckette, Edmund	**190**	St. Louis
Beckman, Robert F.	**002**	St. Louis
Beckmann, Charles R.B.	**125**	Overland Park, KS
Bedwinek, John M.	**190**	St. Charles
Beeks, John W.	**125**	Kansas City
Beesley, Kari	**002**	Kansas City
Beggs, Charles W.	**050**	Liberty
Beguin, Everett A., Jr.	**082**	Springfield
Behbahani, Parviz M.	**190**	Bridgeton
Beheler, Edward M.	**030**	St. Joseph
Behrend-Uhls, Ann E.	**042**	Cape Girardeau
Behrends, Steven H.	**125**	Kansas City
Behrens, Donald T.	**190**	St. Louis
Behrens, Gerald L.	**190**	St. Louis
Beitman, Bernard D.	**026**	Columbia
Belden, Jeffery L.	**026**	Columbia
Belen, Marietta	**106**	Festus
Belew, Mark	**190**	Florissant
***Beliel, Steven G.**	**126**	Merriam, KS
Bell, Gordon A.	**125**	Overland Park, KS
Bell, Laird A.	**082**	Springfield
Bell, Malinda H.	**125**	Shawnee Mission, KS
Bell, Martin J.	**190**	St. Louis
Bell, Stephen	**190**	St. Louis
Bell, William F.	**125**	Lee's Summit
Bellamy, Bruce G.	**086**	Clinton
Beller, Thomas A.	**125**	Kansas City
Belshe, Sidney B.	**058**	Jefferson City
***Belson, Ian L.**	**125**	Kansas City
Belz, Norbert T.	**082**	Springfield
Benage, Clarence M.	**190**	St. Louis
Benecke, James E., Jr.	**190**	St. Louis
Benedett, Robert E.	**082**	Springfield
Benedict, Holly J.	**082**	Ozark
Benedict, William W.	**190**	Chesterfield
Benitez, Jose A.	**190**	St. Louis
Bennett, Danny L.	**125**	Kansas City
Bennett, Donald R.	**027**	Columbia
Bennett, James D.	**125**	Leawood, KS
Bennett, John E.	**058**	Jefferson City
Bennett, Kenneth J.	**190**	St. Louis
Benoist, Walter F.	**190**	Chesterfield
Benson, Larry E.	**050**	N. Kansas City
Benson, Ronald G.	**082**	Springfield
Benson, Russell L.	**125**	Kansas City
Benson, William F.	**125**	Kansas City
Bentlage, Charles H.	**102**	Joplin
Bentley, John D.	**082**	Springfield
Benton, Mary Beth	**026**	Columbia
Berdy, Gregg J.	**190**	St. Louis
Berdy, Susan S.	**190**	St. Louis
Berg, Edward F.	**190**	Chesterfield
Berg, Leonard	**190**	St. Louis
Berg, Ralph	**190**	St. Louis
Berger, Gary G.	**125**	Overland Park, KS
Bergmann, Daniel J.	**189**	St. Peters
Berkowitz, Ellis R.	**030**	St. Joseph
Berkowitz, Wallace P.	**190**	St. Louis
Berland, David I.	**190**	Chesterfield
Berland, Harry I.	**190**	St. Louis
Berman, Paul M.	**190**	St. Louis
Berman, William	**190**	St. Louis
Bernabe, Florinio H.	**190**	St. Louis
Bernabe, Ofelia M.	**190**	St. Louis
Bernard, Jennifer P.	**126**	Overland Park, KS
Bernard, Lisa	**125**	Kansas City
Bernardi, Robert J.	**190**	St. Louis
Berndsen, Gerard H.	**190**	St. Louis
Berner, Carol T.	**082**	Springfield
Bernhardson, Paul D.	**026**	Columbia
Bernhardt, Gary D.	**125**	Overland Park, KS
Bernhardt, Mark	**125**	Kansas City
Berni, Anthony A.	**190**	St. Louis
Bernstein, Aaron M.	**190**	St. Louis
Berry, Danny T.	**042**	Cape Girardeau
Berry, Maxwell G.	**125**	Prairie Village, KS
Berry, Paul T.	**082**	Springfield
Berson, Douglas R.	**002**	Chesterfield
Berwald, David M.	**190**	Bridgeton
Berwald, Irvin I.	**190**	Bridgeton
Bessonny, Eric J.	**190**	Naperville, IL
Best, John A.	**190**	Chesterfield
Bettinger, Irene E.	**125**	Kansas City
Bettonville, Peter V.	**190**	St. Louis
Betz, Richard J.	**166**	Neosho
Betz, Robert F.	**166**	Neosho
***Betz, William T.**	**125**	Grandview
Bever, Grant A.	**190**	St. Louis
Bhattacharya, Arjun	**190**	St. Louis
Bhothinard, Bhisit	**034**	Poplar Bluff
Biber, Robert J.	**125**	Independence
Bickley, James E.	**125**	Evergreen, CO
Biek, Richard W.	**190**	St. Louis
Biel, Stanley I.	**190**	Bridgeton
Bieniek, Christopher M.	**150**	Hannibal
Biery, Richard M.	**125**	Kansas City
***Bieser, R. Dan**	**042**	Cape Girardeau
Biggs, Alfred D., Jr.	**125**	Kansas City
Biggs, Fred J.	**034**	Poplar Bluff
Biggs, Harry L.	**125**	Galena
Biggs, John	**190**	St. Louis
Billadello, Joseph J.	**002**	St. Louis
Billy, Lawrence J.	**190**	St. Louis
Bindbeutel, Donald A.	**190**	Chesterfield

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Binnington, H.B.	190	St. Louis
Binz, Donald E.	189	St. Peters
Birchansky, Bonnie-Lee	030	St. Joseph
Bircher, John L.	190	St. Louis
Bird, H. Waldo, Jr.	190	St. Louis
Birenboim, Nancy	125	Kansas City
Birge, Clifford A.	190	St. Louis
Birkby, William F.	026	Columbia
Birmingham, Jean E.	190	St. Louis
Birnbaum, Elisa H.	190	St. Louis
Bishop, Marion D.	190	St. Louis
Bitar, Saad R.	195	Manchester
Bittle, Bradley K.	042	Cape Girardeau
Bizek, J.L.	166	Aurora
Black, David L.	102	Joplin
Black, Joseph T.	190	St. Louis
Black, William R.	102	Neosho
Blackburn, Michael D.	026	Columbia
Blackburn, Timothy L.	125	Kansas City
Blackwell, Charles R.	190	St. Louis
Blackwell, Charles W.	026	Columbia
Blaine, James R.	082	Springfield
Blair, Jerry R.	026	Columbia
Blair, Olga M.	190	Orlando, FL
Blair, Vilray P., III	190	St. Louis
Blalock, Robert W.	198	Marshall
Blank, Michael K.	106	De Soto
Blanke, Thomas J.	190	St. Louis
Blankenship, Dale M.	042	Savannah, GA
Blaskiewicz, Robert J.	190	St. Louis
Blath, Richard A.	190	St. Louis
Blatt, Geoffrey L.	125	Kansas City
Blim, R. Don	125	Kansas City
Bliss, Greg A.	125	Blue Springs
Block, Arnold S.	190	St. Louis
Bloom, Stephen A.	125	Overland Park, KS
Bloomberg, Gordon R.	190	Chesterfield
Bluestone, Kenneth I.	125	St. Louis
Blum, Carol A.	002	Excelsior Springs
Blum, Donald A.	190	St. Louis
Blum, Philip C.	125	Kansas City
Blythe, James G.	190	St. Louis
Boatright, Kevin	138	Farmington
Bode, Eugene T.	125	Kansas City
Boedeker, James P.	190	St. Louis
Bogard, Phyllis J.	030	St. Joseph
Bogart, Douglas B.	125	N. Kansas City
Bogner, Stuart M.	190	St. Louis
Bohigian, George M.	190	St. Louis
***Bohn, Sara A.**	058	California
Bohn, William W.	125	Kansas City
***Boice, Brett E.**	102	Joplin
Boice, Michelle A.	102	Joplin
Boland, Michael F.	190	Chesterfield
Boldizar, Albert G.	190	St. Louis
Boldt, Thomas H.	190	Bridgeton
Boles, C.R.	190	St. Louis
Boles, Murray	026	Columbia
Bolinske, Robert E.	190	St. Louis
Bollier, Rene P.	125	Kansas City
Bollozos, George D.	190	Ballwin
Bonacorsi, John	190	Bridgeton
Bonar, Susan K.	125	Kansas City
Bondurant, Charles P.	026	Columbia
Bonebrake, Albert J.	082	Springfield
Bonebrake, Mac D.	082	Springfield
Bonfanti, Albert L.	190	Chesterfield
Bonham, Roger D.	026	Columbia
Boniuk, Isaac	190	St. Louis
Bonner, James S.	190	St. Louis
Bonney, Samuel C.	074	Washington
Bono, Gregory L.	125	Lenexa, KS
Bonsanti, Robert L.	190	Bridgeton
Boodram, Mitra B.	190	St. Louis
Boone, Daniel C.	050	Gladstone
Boone, Martin H., Jr.	082	Springfield
Boonshaft, Benje	190	St. Louis
Booth, Randall K.	214	Nevada
Bopp, J. Ronald	102	Seneca
Bordy, Marvin D.	125	Kansas City
Borello, Dan J.	102	Joplin
Borhani, Hesamodin	126	Kansas City
Borja, Egbert R.	082	Springfield
Borkon, A. Michael	125	Kansas City
Borowsky, Benjamin A.	190	St. Louis
Borrego, Raul A.	138	Farmington
Borup, Jerrell L.	082	Springfield
***Bosley, Carl E.**	034	Poplar Bluff
Bost, Roger K.	034	Poplar Bluff
Botney, Kathryn	190	St. Louis
Botwin, Arnold E.	125	Leawood, KS
Bouhasin, John D.	190	St. Louis
Bourgeois, Curtis H.	026	Columbia
Boutwell, Christine M.	126	Kansas City
Boveri, Joseph C.	190	St. Louis
Boveri, Lawrence V.	002	St. Louis
Bowe, Christopher C.	190	St. Louis
Bowen, Stephen F., Jr.	190	St. Louis
Bowenschulte, Bradley A.	082	Springfield
Bower, James S.	125	Kansas City
Bowers, James E.	190	Kirkwood
Bowersox, Warren A.	190	Pacific
Bowles, G. R.	190	St. Louis
Bowles, Richard P.	050	Liberty
Bowman, W. Kirk	042	Cape Girardeau
Bownik, T. Bryan	050	Kansas City
Bowser, John F.	125	Hot Springs, AR
Bowser, Robert L.	050	Independence
Boyarsky, Saul	190	St. Louis
Boyce, John M.	178	Blue Springs
Boyd, Craig W.	190	St. Louis
Boydston, Catherine O.	118	Odessa
Boydston, Wyatt W.	118	Odessa
Boyer, Peter A.	058	Jefferson City
Boylan, Peter C.	125	Kansas City
Brabbee, Gregory W.	190	St. Louis
Brabson, John H.	082	Springfield
Braby, Howard H.	125	Independence
Bradbury, George R., III	190	Bridgeton
Braddock, Stephen	026	Columbia
Bradford, John F.	125	Shawnee Mission, KS
Bradley, Richard V.	190	St. Louis
Bradshaw, William D.	125	Kansas City
Brady, Harry R.	190	St. Louis
Brady, Hugh S.	118	Concordia
Brady, Jane R.	190	St. Louis
Brady, Teresa M.	125	Lee's Summit
Brancato, Donald H.	190	St. Louis
Brangle, Robert W.	190	St. Louis
Branham, Gregory H.	190	St. Louis
Braun, Alan L.	058	Jefferson City
Braun, William J.	125	Kansas City
Braverman, Abe E.	125	Overland Park, KS
Braverman, Stuart J.	178	Sedalia
Braxton, Frank W.	042	Cape Girardeau
Brazos, John C.	178	Sedalia
Breckenridge, Robert L.	050	Kansas City
Bredemann, Jeffrey A.	125	Kansas City
Breeding, Lyle G.	026	Columbia
Bregant, Robert E.	058	Jefferson City
Brehm, G. Scott	102	Joplin
Brehm, Martha A.	102	Joplin
Breite, Warren M.	106	Festus
Brennan, George A.	190	St. Louis
Brennan, James M.	190	St. Louis
Brennan, Richard J.	030	St. Joseph
Brennan, Robert A., Jr.	190	St. Louis
Brennan, Robert A., Sr.	190	St. Louis

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Brennan, Robert V.	190	St. Louis
Brent, Lanny R.	082	Springfield
Bresnahan, Dennis R.	125	Kansas City
Brewer, Joseph H.	125	Kansas City
Brian, William J.	082	Springfield
Bricker, Eugene M.	190	St. Louis
Brigden, Robert B.	102	Neosho
Briggs, Thomas B.	082	Springfield
Brigham, David W.	190	Ballwin
Bright, James E.	082	Springfield
Brink, David S.	190	St. Louis
Brinkman, Robert A.	190	Chesterfield
Brischetto, Michael J.	190	St. Louis
Britt, Cornelius L.	106	Crystal City
Britton, Loretta M.	125	Kansas City
Broaddus, Loren E.	082	Springfield
Brock, Arthur L.	125	Independence
Brockhaus, Jayne R.	110	Warrensburg
Brockman, M. Douglas	082	Springfield
***Brocksmith, James T.**	026	Columbia
Brodeur, Armand E.	190	St. Louis
Brodkey, Mark J.	125	Kansas City
Brody, Arnold G.	190	St. Louis
***Bronson, Wendell D.**	030	St. Joseph
Brook, Charles J.	125	Kansas City
Brookes, Robert D.	190	Chesterfield
Broun, Goronwy O., Jr.	190	St. Louis
Brown, Barry D.	190	St. Louis
Brown, Cynthia L.	034	Poplar Bluff
Brown, David W.	082	Springfield
Brown, Elwyn S.	125	Kansas City
Brown, Frederick B.	166	Aurora
Brown, Freeman F., III	190	Ballwin
Brown, James T.	082	Springfield
Brown, Marilyn	195	Florissant
Brown, Merlin D.	030	St. Joseph
Brown, Mike J.	042	Cape Girardeau
Brown, Norbert W.	125	Kansas City
Brown, Randy G.	125	Kansas City
Brown, Rebecca L.	082	Springfield
Brown, Robert J.	189	St. Charles
Brown, Robert S.	125	Shawnee Mission, KS
Brown, Seymour	190	Chesterfield
Browne, Jon E.	125	Kansas City
Browning, Sarah E.	126	Kansas City
Brownsworth, Ronnie D.	082	Springfield
Bruce, Leo A.	202	Sikeston
Bruce, Robert P.	125	Kansas City
Brukardt, Diane T.	026	Columbia
Brumfield, Amy S.	126	Kansas City
Bruno, Patrick L.	150	Hannibal
Bruns, Kenneth	190	St. Louis
Brunt, L. Michael	190	St. Louis
Brunts, John T.	195	St. Louis
Brunworth, David	074	Washington
Bryant, Lester R.	026	Columbia
Bryant, T. J.	125	Kansas City
Bryant, William A.	202	Sikeston
Bryer, Mark P.	026	Columbia
Buchanan, Barbara N.	125	Belton
Buchele, Alan M.	102	Joplin
Bucher, William C.	026	Columbia
Buchert, Peter K.	026	Columbia
Bucholz, Richard D.	190	St. Louis
Buchwach, Kenneth A.	125	Independence
Buckner, John W.	082	Springfield
Buckner, Robert C.	125	Shawnee Mission, KS
Bucol, Kevin D.	190	St. Louis
Budd, John J., Jr.	190	St. Louis
Buehler, Carl T., Jr.	120	Eldon
Buettner, John B.	190	Chesterfield
Buffaloe, Robert N.	058	Jefferson City
Buie, Bruce R.	125	Kansas City
Buie, Steven E.	125	Kansas City
Bukstein, Michael J.	150	Hannibal
Bult, Mark J.	082	Nixa
Bumberry, John R.	082	Springfield
Bumgarner, James E.	026	Columbia
Bumgarner, Roger W.	026	Columbia
Bunge, Nancy J.	014	Mexico
Bunting, Williston P.	125	Kansas City
Burch, John E.	102	Naples, FL
Burch, Timothy K.	125	Overland Park, KS
Burdge, Robert E.	190	St. Louis
Burford, Edwin K.	042	Cape Girardeau
Burgdorf, Max H.	190	Bridgeton
Burgess, Dean	190	St. Louis
Burk, Emmett K.	050	Plano, TX
Burke, James S., Jr.	190	St. Louis
Burkey, Jordan W.	082	Springfield
Burkhart, Edward F.	190	Delray Beach, FL
Burks, Michael L.	026	Columbia
Burleigh, Bruce W.	102	Joplin
Burmeister, R. William	190	St. Louis
***Burns, Bernard C., III**	042	Cape Girardeau
Burns, Bryan W.	126	Overland Park, KS
Burns, Edward L.	190	St. Louis
Burns, Francis J.	190	St. Louis
Burns, Michael F.	190	St. Louis
Burns, Thomas W.	026	Columbia
Burris-Velloff, Tara M.	125	Prairie Village, KS
Burroughs, Nathan D.	050	N. Kansas City
Burry, Virgil F.	125	Blue Springs
Burst, Donald O.	190	Key Largo, FL
Burstein, Robert	190	St. Louis
Burton, Curtis D.	150	Hannibal
Buse, Paul E.	190	St. Louis
Busiek, Paul J.	082	Springfield
Busse, Paul P.	190	St. Louis
Bussmann, Carl E.	190	Bridgeton
Bussmann, Donald W.	190	Chesterfield
Bussmann, Donald W., Jr.	082	Springfield
Bussmann, Yvonne L.	082	Springfield
Butin, Richard E.	125	Kansas City
Butler, David F.	190	Chesterfield
Butler, Elza F.	030	St. Joseph
Butler, Susan M.	058	Jefferson City
Butsch, Richard H.	190	St. Peters
Butterfield, Mari Anne	125	Lee's Summit
Butterworth, Nelson S.	125	Kansas City
Byars, Steven R.	125	Kansas City
Byland, Samuel J.	146	Wellsville
***Bynum, Carl G.**	058	Jefferson City
***Bynum, Robert L.**	026	Ashland
***Byrne, Kevin G.**	120	Osage Beach
Byrum, Fritz A.	190	Ballwin

C

Cabbabe, Edmond B.	190	St. Louis
Cabral, Galileu	190	Florissant
Cabrera, Tomas V.	189	St. Peters
Cacioppo, Joseph E.	190	St. Louis
Cadice, John B.	190	St. Louis
Cadiz, Briccio S., III	174	Ste. Genevieve
Cady, Roger K.	082	Springfield
Caffrey, Raymond J.	125	Independence
Caffrey, Robert T.	125	Independence
Cain, Alvin R.	018	Lamar
Calabria, Rafael	214	Nevada
Calaluce, Robert	027	Columbia
Caldwell, Fred	034	Poplar Bluff
Caldwell, Fred M.	034	Poplar Bluff
Caldwell, Joseph L.	082	Springfield
Calhoun, Joshua W.	190	St. Louis
Callahan, Joseph D.	190	St. Louis
Callaway, Guy D., Jr.	082	Springfield
Callaway, Jo J.	125	Kansas City
Callaway, Lawrence A.	125	Kansas City
Callicoat, Paul E., Jr.	102	Joplin

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Calodney, Martin M.	190	St. Louis
Calovich, Emery R.	125	Shawnee Mission, KS
Camarata, Paul J.	125	Kansas City
Camejo, Manuel	082	Springfield
***Cameron, Roger W.**	058	Jefferson City
Camp, Alan D.	002	Bridgeton
Campbell, Albert J.	178	Sedalia
Campbell, Daniel C.	166	Mt. Vernon
Campbell, David C.	190	St. Louis
Campbell, Edward D.	042	Cape Girardeau
Campbell, Gregory S.	026	Columbia
Campbell, J. William	190	St. Louis
Campbell, James E.	046	Macon
Campbell, James W.	202	Advance
Campbell, William S., Jr.	042	Cape Girardeau
Campos, Francisco J.	190	St. Louis
Canaan, Samuel A., Jr.	190	St. Louis
Canby, Robert C.	125	Kansas City
Canent, Ramon V.	125	Kansas City
Canlas, Mario P.	082	Springfield
Cannistraro, Rosemary L.	190	Clayton
Cannon, Jenifer M.	190	St. Louis
Cannon, Max K.	148	Kirksville
Cannon, Richard E.	189	St. Charles
Cantor, Harvey E.	190	St. Louis
Canty, Eugene J.	189	St. Charles
Caplin, David A.	190	St. Louis
Caputo, Cynthia J.	125	Raytown
Carden, Juan O.	190	St. Louis
Cardone, John C.	125	N. Kansas City
Cardwell, Daniel R.	066	Bolivar
Carey, Larry J.	082	Springfield
Cargill, Dianna L.	050	Liberty
Carleton, Charles E.	138	Farmington
Carlin, M. Richard	190	St. Louis
Carls, Garry L.	190	Imperial
Carlson, Arne E.	190	St. Louis
Carlson, John V.	014	Mexico
Carlton, Lynn N.	082	Springfield
Carmody, John P.	190	St. Louis
Carnahan, Charles E.	026	Columbia
Carnes, Victor M.	102	Durham, NC
Carney, Stephen E.	202	Sikeston
Carney, Susan M.	050	Kansas City
Carolla, Robert L.	082	Springfield
Carpenter, George T.	030	St. Joseph
Carpenter, James L.	189	St. Peters
Carpenter, Wallace	158	Rock Port
Carr, George W.	058	Jefferson City
Carr, Phillip W.	082	Reeds Spring
Carranza, Mauro J.	190	St. Louis
Carrier, John A.	190	Ballwin
Carrington, Howard W.	115	Lebanon
Carroll, Thomas W.	018	Lamar
Carter, Edwin E.	190	St. Louis
Carter, Gary L.	050	N. Kansas City
Carter, James E., Jr.	125	Leawood, KS
Carter, James R.	166	Neosho
Carter, Robert L.	102	Joplin
Caruso, A. Cosmo	126	Kansas City
Caruso, Alfred A.	125	Kansas City
Caruso, Peter J.	125	Kansas City
Cary, John M.	190	Chesterfield
Case, Mary E.	190	St. Louis
Case, William F.	125	Kansas City
Casement, Brian A.	125	Kansas City
Casey, Arthur L.	190	St. Louis
Casey, Eliot C.	190	St. Louis
Cashman, John W.	125	Shawnee Mission, KS
Cason, Elbert H.	190	St. Louis
Cassat, James D.	074	Washington
Castaneda, Marco A.	190	Bridgeton
Caster, Philip W.	115	Lebanon
***Castle, Nial K.**	126	Lenexa, KS
Catanzaro, Frank J., Jr.	190	St. Louis
Catanzaro, Frank J., Sr.	190	St. Louis
Catanzaro, Rudolph E.	190	St. Louis
Cates, Joe A.	125	Kansas City
Catron, David O.	042	Cape Girardeau
Caughron, Michael R.	125	Kansas City
Causey, Michael S.	195	Chesterfield
Cavero, Fernando L.	066	Bolivar
Centner, Paul J.	125	Prairie Village, KS
Cento, Donald P.	202	Sikeston
Cernik, Christine C.	190	St. Louis
Chaffin, Jerald D.	208	Branson
Chalk, David E.	074	Washington
Chalkley, Judson I.	026	Columbia
Chambon, Gregory E.	125	Kansas City
Chamness, James T.	190	St. Louis
Chan, Celia L.	042	Cape Girardeau
Chanasue, John A.	190	Florissant
Chand, Nilima P.	138	Bonne Terre
Chand, Sunil C.	138	Bonne Terre
Chandler, R. Allen	125	Kansas City
***Chandra, Ram**	118	Higginsville
Chandramohan, Nanjappa	102	Carthage
Chang, Chil K.	026	Columbia
Chantler, Marcia L.	195	St. Louis
Chapman, James B.	042	Cape Girardeau
Chapman, Jean A.	042	Cape Girardeau
Charapata, Steven G.	125	Kansas City
Charette, Richard P.	125	Kansas City
Charles, Elaine Z.	190	St. Louis
Charles, Francois	190	St. Louis
Charnas, Raymond M.	190	St. Louis
Charnond, Siroth	195	Brentwood
Chase, Larry K.	082	Springfield
Chase, Ned B.	102	Joplin
Chastain, Charles W.	138	Bonne Terre
Chatfield, Gina K.	027	Columbia
Chaudhari, A. Basit	042	Cape Girardeau
Chaudhuri, Tapan K.	125	Lee's Summit
Chauhan, Nazar C.	034	Poplar Bluff
Chavez, Salvador	190	St. Louis
Cheek, Charles W.	026	Rocheport
Chehval, Micheal J.	190	St. Louis
Chern, Mou S.	206	Ava
Chernoff, Selbert G.	125	Lee's Summit
Cherre, Charles J.	190	Chesterfield
Chesney, George W.	102	Joplin
Chesney, John W.	102	Joplin
Cheuk, Shu-Sum	190	Chesterfield
Cheung, K. Charles	042	Cape Girardeau
Chien, David W.	190	Maryland Heights
Chilton, Jonathan D.	125	Kansas City
Chin, Mark Maw-Chang	190	Chesterfield
Chinsky, Murray	190	St. Louis
Chipongian, Raul A.	190	St. Louis
Chirino, Octavio R.	190	St. Louis
Chishti, M. Ishaq	190	St. Louis
Cho, Kyu S.	190	St. Louis
Chod, Ronald J.	190	St. Louis
Choi, Dennis W.	190	St. Louis
Choi, Sei Young	189	St. Charles
Chou, Wesley H.	125	Overland Park, KS
Choudhury, M. Hasan	206	Springfield
Chouinard, Michael P.	202	Sikeston
Christ, Martin H.	030	St. Joseph
Christiansen, Sidney G.	030	St. Joseph
Christiansen, Stephen D.	082	Springfield
Christianson, Charles S.	166	Mt. Vernon
Christy, John P.	034	Poplar Bluff
Christy, Raymond A.	082	Springfield
Chu, Fred C.	190	Chesterfield
Chu, Paul R.	125	Independence
Chu, Peter Y.	125	Kansas City
Chun, Chung S.	125	Kansas City

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Chun, Duck Sung	St. Louis	190
Chung, Kap Eun	Fredericktown	138
Chung, Sophia M.	St. Louis	190
Chung, T. David	Poplar Bluff	034
Churchill, Robert J.	Columbia	026
Ciapciak, Stanley J.	St. Louis	190
Cibis, Gerhard W.	Kansas City	125
Cirocco, William C.	Shawnee Mission, KS	125
Clark, David B.	Springfield	085
Clark, David P.	Columbia	026
Clark, Granville E.	Kansas City	125
Clark, Jennifer L.	Columbia	026
Clark, Larry K.	Joplin	102
Clark, Mark S.	Independence	126
Clark, Robert C.	St. Joseph	030
Clarke, Michael J.	Springfield	082
Clarke, Michael S.	Springfield	082
Clarke, Paul W.	Cape Girardeau	042
Clarkston, Kendell C.	Kansas City	126
Claseman, Wilma W.	St. Louis	190
Clawson, James W.	Springfield	082
Clayton, Edgar L.	Springfield	082
Clemens, Robert M.	Sedalia	178
Clement, Donald J.	Kansas City	125
Clever, Henry W.	St. Charles	189
Clever, Victor G.	St. Charles	189
Cline, Merle A.	Kansas City	125
Clothiaux, Pierre L.	Springfield	082
Clothier, Robert W.	Independence	125
Clouse, John W.	Springfield	082
Coates, James G.	St. Louis	002
Cobb, Milton L.	St. Louis	190
Cochran, David S.	Springfield	082
Cochran, Thomas E.	Springfield	082
Cockerell, Charles F.	Blue Springs	125
Cockerell, Sanford F.	Independence	125
Cockrell, Steven N.	Hannibal	150
Codd, John E.	Bridgeton	190
Coe, Tracy L.	Joplin	102
Coffin, Helen K.	Shawnee Mission, KS	125
***Coffman, Avon C.**	Kansas City	125
Cogley, Patrick J.	Nixa	208
***Cohen, Donald L.**	Overland Park, KS	125
Cohen, Edward	St. Louis	190
Cohen, Faye C.	Chesterfield	190
Cohen, Harry B.	Mexico	014
Cohen, Hillard K.	St. Ann	190
Cohn, Steven G.	Kansas City	125
Coin, Richard E.	St. Louis	190
Cokingtin, Cliff	Overland Park, KS	125
Cokingtin, Diana L.	Kansas City	125
Cokingtin, Leovigildo C.	Independence	125
Colapinto, Edward V.	Columbia	026
Colbert, Dennis G.	St. Louis	190
Colbert, Robert S.	Sikeston	202
Cole, Donald E.	Springfield	066
Cole, Harry O.	Chesterfield	190
Cole, Sherman W.	Kansas City	125
Cole, William R.	Sedalia	178
Coleman, Kevin A.	St. Louis	190
Coleman, Matthew J.	Cape Girardeau	042
Coleman, Terrence W.	Liberty	125
Colglazier, Mary C.	Lee's Summit	125
Collins, Samuel B.	Columbia	026
Collison, R. Michael	Springfield	082
Colom, George A.	Kansas City	125
Colwill, Jack M.	Columbia	026
Comas, Manuel R.	St. Louis	190
Comfort, George D.	Mexico	014
Commerford, John F.	St. Charles	189
Conant, James F.	St. Joseph	030
Conger, Susan C.	St. Louis	190
Conley, Brian S.	Jefferson City	058
Conn, Robert D.	Kansas City	125
Conrad, Marshall B.	St. Louis	190
Contogiannis, Mary Ann C.	Kansas City	126
Convery, Paul B.	St. Louis	190
Conway, Robert R.	Columbia	026
Cook, James R.	Springfield	082
Cook, Katherine S.	Rolla	135
Cook, Marvin A.	St. Louis	190
Cook, Paul R.	Columbia	026
Cook, Thomas B.	Richmond	118
Cooksey, Jon D.	St. Louis	190
Coonce, Don C.	Cape Girardeau	042
Cooper, Barry J.	St. Louis	190
Cooper, Barry R.	N. Kansas City	050
Cooper, Gary D.	Liberty	050
***Cooper, Glen E.**	Columbia	026
Cooper, Robert L., II	Warrensburg	110
Cooper, Thomas J.	Farmington	190
Coordes, Cordie C.	Chesterfield	190
Coordes, Kathleen M.	St. Louis	190
Cope, James C.	Sanibel, FL	026
Copeland, Jeffrey G.	St. Charles	189
Copeland, Jessie L., Jr.	Kansas City	126
Copp, Ralph	St. Louis	190
Coppinger, Thomas A.	Kansas City	125
Corcoran, Francis H.	Joplin	102
Corcoran, Michael J.	Birmingham, AL	026
Cordell, Larry D.	Kansas City	125
Corder, James C.	St. Louis	190
Corder, Patricia G.	St. Louis	190
Corder, Robert L.	St. Joseph	030
Cornwell, Karen R.	Kansas City	125
Corrado, Joseph A.	Mexico	014
Corry, Francis M.	Springfield	082
Corry, James M.	St. Louis	190
Cort, David H.	St. Louis	190
Cortese, Cherise	Kirkwood	195
Cortner, Mary C.	Kansas City	125
Corvalan, Juan C.	St. Louis	190
Corwin, Kenneth D.	St. Louis	190
***Corzine, John J.**	St. Joseph	030
Coscia, Robert L.	Springfield	082
Costello, Joseph P., Jr.	Chesterfield	190
Costen, William S.	Chesterfield	190
Costin, Jimmy L.	Poplar Bluff	034
Cotton, Thomas R.	Kansas City	125
Couchman, Ryan W.	St. Louis	190
Couper, Nicholas B.	Columbia	026
***Courter, Gary M.**	Lebanon	115
Courter, Larry P.	Osage Beach	058
Cova, Reno R.	Cape Girardeau	042
Covarrubias, Jorge A.	Phoenix, AZ	190
Covert, Richard A.	St. Louis	190
Cowden, John W.	Columbia	026
Cox, Curtis S.	Jefferson City	058
Cox, James L.	St. Louis	190
Cox, Jeffrey L.	Joplin	102
***Cox, John M.**	Joplin	102
Cox, John P.	Amazonia	030
Cox, Mark T.	Sedalia	178
Coxe, William S.	St. Louis	190
Coyne, Patrick M.	Bridgeton	190
Cozad, Scott C.	Kansas City	125
Cozean, Charles H.	Cape Girardeau	042
Crabtree, H. Mark	Springfield	082
Cradock, Thomas V.	St. Louis	190
Crafts, David	St. Louis	190
Craig, Alan G.	St. Louis	190
Craig, Richard O.	St. Joseph	030
Craig, Robert D.	St. Louis	002
Craighead, Michael L.	Jefferson City	058
Cram, John W.	Springfield	082
Cramer, Quentin	Kansas City	125
Crandall, Richard E.	Chesterfield	190
Crane, John B.	Washington	074

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Crane, James P.	190	St. Louis
***Crane, William G.**	126	Lenexa, KS
Cravens, David D.	027	Centralia
Cravens, William P.	038	Fulton
Craver, Jeffrey L.	190	Bridgeton
Crawford, Oral B.	082	Springfield
Creech, Fred T.	026	Cape Coral, FL
Creighton, Christopher P.	002	Morgantown, WV
Crepps, Louis F.	190	St. Louis
Crespin, Stephen R.	190	St. Louis
Crespo, Horacio T.	074	Warrenton
Crespo, Remedios R.	074	Warrenton
Creswell, Lawrence L.	195	Chesterfield
Crie, J. Stanley	030	St. Joseph
Crighton, John C.	082	Springfield
Criscione, James R., Jr.	190	St. Louis
Criscione, James R., Sr.	190	St. Louis
Criscione, James S.	190	St. Louis
Critchlow, J. Thomas	042	Cape Girardeau
Critchlow, Michael E.	042	Cape Girardeau
Crockett, James E.	125	Kansas City
Crockett-Maples, Melinda	082	Springfield
Cronemeyer, Richard L.	125	Lee's Summit
Crosby, William H.	102	Joplin
Crosnoe Janna R.	042	Cape Girardeau
Crotty, John P.	190	St. Louis
Crouch, John A.	026	Columbia
Croughan, Jack L.	190	St. Louis
Crow, Martin L.	125	Kansas City
***Crowell, Tamara E.**	125	Lee's Summit
Crowley, William J.	026	Spicewood, TX
Croy, David W.	102	Joplin
Crumpacker, Margaret	190	St. Louis
Crumpacker, Rex K.	102	Joplin
Cruz, Sergio G.	166	Monett
Cryer, Philip E.	190	St. Louis
Cuddihee, Robert E.	190	St. Louis
Culver, Perry J., Jr.	125	Kansas City
Cummings, Kenneth C.	125	Kansas City
Cummings, Steven W.	190	Brentwood
Cundiff, H. Clay	125	Independence
Cunningham, D. Dean	082	Springfield
Cunningham, Edwin J.	190	Chesterfield
Cunningham, Milamari A.	026	Columbia
Cunningham, R. Raymond	026	Columbia
Cunningham, William F.	082	Springfield
Cupp, Gerald V.	026	Columbia
Curnow, Richard B.	050	Liberty
Curran, Terrence	125	Kansas City
Curry, D. Troy	190	St. Louis
Curry, Michael D.	026	Columbia
Curry, Michael J.	189	St. Charles
Curtis, Jack J.	026	Columbia
Custer, Galen M.	125	Overland Park, KS
Cusumano, Joseph V.	190	St. Louis
Cusworth, Robert	189	St. Charles
Cutler, Harold M.	190	St. Louis
Cygan, Ronald W.	125	Kansas City
Cyriac, George K.	014	Mexico
Czebrinski, Edward W.	190	Chesterfield

D

***D'Angelo, James A.**	126	Kansas City
Daake, John W., Jr.	190	St. Louis
Daake, John W., Sr.	190	St. Louis
Dabbs, Wilbur D.	166	Neosho
Dacey, Ralph G., Jr.	190	St. Louis
Dagartzikas, A. K.	190	St. Louis
Dahlberg, Thomas E.	082	Springfield
Dahm, Charles H., Jr.	190	St. Louis
Daily, Bill B.	002	St. Louis
Daily, James M.	082	Springfield
Dalton, Timothy T.	125	Kansas City
Daly, James W.	026	Gainsville, FL
***Daly, Michael M.**	026	Columbia
Dames, Richard J.	190	Chesterfield
Dandridge, Walter C.	102	Joplin
Danforth, William H.	190	St. Louis
Dang, Robert C.	214	Pleasant Hill
Daniel, A. E.	026	Columbia
Daniels, John S.	002	St. Louis
***Daniels, William B.**	125	Kansas City
Danielsson, Ernst P.	082	Springfield
Dankner, Arnold	190	Chesterfield
Dankner, Rand E.	190	Chesterfield
Danner, Shavonne L.	125	Leawood, KS
Danuser, Carol B.	026	Columbia
Darby, Patric J.	027	Columbia
Darkow, Grant V.	026	Columbia
Darmadi, Daniel D.	190	Kansas City
Darmadi, Michael H.	195	Manchester
Darnell, Dale E.	125	Kansas City
Dash, Udaya N.	190	Bonita Springs, FL
Dattel, F. Scott	002	Overland Park, KS
Daum, Harold F.	178	Sedalia
Daus, Arthur S.	102	Joplin
Davault, George K.	118	Richmond
Davidner, Mark L.	125	Kansas City
Davidson, Morris	190	St. Louis
Davidson, Raymond P.	190	St. Louis
Davis, Bradley E.	125	Overland Park, KS
Davis, Carl S.	125	Lee's Summit
Davis, Charles S.	102	Galena, KS
Davis, Cynthia L.	150	Hannibal
Davis, Donald R.	125	Prairie Village, KS
Davis, Gene L.	190	Chesterfield
Davis, Herbert V.	125	Kansas City
Davis, J. Lawrence	190	St. Louis
Davis, Jack M.	125	Kansas City
Davis, Kimberly K.	125	Independence
***Davis, Larry E.**	050	N. Kansas City
Davis, Leonard L.	014	Columbia
Davis, Mary A.	190	St. Louis
Davis, Richard C., Jr.	026	Columbia
Davis, Sheldon	190	Florissant
Davis, Thomas N.	138	West Plains
Davis, William E.	026	Columbia
Davisson, Walter F.	058	Jefferson City
Davuluri, Sreenadha R.	030	St. Joseph
Day, Chester L.	125	Prairie Village, KS
Dean, Philip D.	074	Washington
Dean, Walter E.	158	Maryville
Deane, Louis V., Jr.	190	St. Louis
Deckard, Shelby W.	082	Springfield
Decker, Albert I.	082	Springfield
***Deffenbaugh, Larry D.**	102	Joplin
Dehner, Jonathan D.	190	St. Louis
Dehner, Louis P.	190	St. Louis
Dehning, Doug O.	125	Independence
Deisher, David M.	042	Cape Girardeau
***Dekker, Anthony H.**	125	Kansas City
deLeeuw, Karel A.	082	Springfield
Del Pizzo, Ferdinand	189	St. Charles
Del Priore, Lucian V.	002	St. Louis
Del Rosario, John E.	190	St. Louis
Del Santo, Peter B.	026	Columbia
Del Valle, Fernando	190	Margate, FL
***Delaney, Adrain J., Jr.**	125	Kansas City
Delcambre, Marie A.	125	Kansas City
Deleste, Carlos J.	106	Festus
Deligeorges, John	002	Kansas City
Dell, Robert V.	150	Hannibal
Dembinski, David R.	125	Kansas City
Dement, Oman E.	102	Joplin
Demmy, Todd L.	026	Columbia
Dempsey, Herbert A.	125	Lee's Summit
***Dempsey, Herbert E.**	125	Lee's Summit
Dempsey, Kenneth J.	202	Sikeston
Dempsey, Maureen E.	026	Columbia

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Denk, Alan F.	190	St. Louis
Denninghoff, James C.	026	Columbia
Denninghoff, James S.	026	Columbia
Derrington, Kenneth L.	120	Laurie
Desai, Alpana A.	195	St. Louis
Desio, Marcus A.	102	Joplin
Dettmer, Robert F.	138	Ironton
Devabhaktuni, Rama Devi	190	Chesterfield
Dever, Robert L.	102	Joplin
Devine, Mark W.	050	N. Kansas City
Devineni, V. Rao	190	Bridgeton
Devins, George S.	125	Kansas City
Devkota, Jagadishwar	026	Columbia
Dew, Thomas A.	190	Chesterfield
Dewald, Paul A.	190	St. Louis
Dewein, Edward G.	190	St. Louis
Dexheimer, Frank R.	026	Columbia
Dexter, J. Kent	082	Springfield
Dexter, James D.	026	Columbia
DeBelen, Arnold Z.	150	Canton
DeBoard, James W.	190	St. Louis
DeCastro, Fernando J.	138	Pilot Knob
DeCoursey, Kenneth A.	042	Cape Girardeau
DeFeo, Frederick G.	125	Kansas City
DeFeo, Theodore C.	125	Kansas City
DeGenova, Gerard H.	174	Ste. Genevieve
DeGuerre, Ronald K.	190	Chesterfield
DeLine, Jim	046	Macon
***DeLucia, Joseph A.**	206	West Plains
DeMotte, Jeanne M.	118	Richmond
DePriest, Michael D.	030	St. Joseph
DeRosa, Michael J.	190	St. Louis
DeSilva, Ananda	190	Hazelwood
DeSpain, John D.	026	Columbia
DeUngria, Pablo C.	190	Bridgeton
DeVera, Anson E.	190	St. Louis
Dick, M. Marga	026	Ashland
Dickerson, Malcolm J.	058	Eldon
Diehl, Elizabeth W.	190	St. Louis
Diemer, David P.	190	St. Louis
Diemer, Peter A.	190	St. Louis
Dierberg, Dale F.	074	Chesterfield
Dierenfeldt, William T.	126	Blue Springs
Dierker, Harry D.	026	Columbia
Diestelhorst, James A.	190	St. Louis
Dieterich, Russell B.	189	St. Charles
Dieterle, Brian D.	208	Branson
Dillard, Erin M.	082	Springfield
Dills, Joseph N.	082	Springfield
Dilworth, Jacquelyn B.	190	St. Louis
Dimayuga, Nestor G.	206	Mansfield
Dinkins, James A.	042	Cape Girardeau
Ditmore, Q. Michael	026	Columbia
***Ditzel, Douglas W.**	102	Joplin
Dix, Patricia M.	082	Springfield
Dixon, Druery J.	206	West Plains
Dixon, G. David	125	Shawnee Mission, KS
Dixon, John R.	078	Brookfield
DiFilippo, Emil A.	189	St. Charles
DiPasco, Donald J.	190	St. Louis
DiValerio, Richard M.	190	St. Louis
Dlabal, Luke J., Jr.	125	Independence
Dmytryk, Eugene T.	190	St. Louis
Doak, Gregory A.	178	Sedalia
Doan, Laura B.	125	Raytown
Doane, John F.	125	Independence
Dobmeyer, Susan M.	190	St. Louis
Dobyan, Dennis C.	030	St. Joseph
Dodge, Philip R.	190	St. Louis
Dodson, Jack M.	058	Jefferson City
Doerhoff, Adelia L.	058	Jefferson City
Doerhoff, Alan R.	058	Jefferson City
Doerhoff, Carl R.	058	Jefferson City
Doerr, Dale E.	190	St. Louis
Doisy, Philip P.	190	St. Louis
Dolan, Patrick H.	190	St. Louis
Domann, Darrel D.	082	Springfield
Dominquez, Jose M.	082	Springfield
Domke, Henry F.	058	New Bloomfield
Donahoe, James L.	190	St. Louis
Donati, Robert M.	190	St. Louis
Donnell, Harold E.	106	De Soto
Donnell, Robert H.	106	Crystal City
Donnell, William S., Jr.	066	Bolivar
Donovan, John F.	190	St. Louis
Donovan, Thomas J.	190	St. Louis
Dorsch, Ervin H.	125	Independence
Dorsch, Stephen E.	125	Independence
Dorton, Robert K.	190	St. Louis
Dorzab, Linda L.	125	Raytown
Dorzab, William E.	125	Overland Park, KS
Dos Santos, Enrique	026	Columbia
Dotson, Lori J.	026	Boonville
Dougherty, Thomas M., Jr.	054	Gladstone
Dowell, George H.	190	St. Louis
Downey, Jon P.	042	Cape Girardeau
Downs, Daniel M.	125	Kansas City
Drake, Roy F.	125	Mission, KS
Drake, William L., Jr.	190	St. Louis
Draney, Thomas E.	125	Hiwasse, AR
***Draper, Richard E.**	042	Cape Girardeau
Dreher, Richard L.	125	Leawood, KS
Drescher, Emmett B.	190	St. Louis
Dresner, Steven M.	026	Columbia
Dreyer, Carl J.	190	St. Louis
Dreyer, Philip V.	046	Huntsville
Driks, Michael R.	125	Kansas City
Driskell, Karen K.	125	Kansas City
Drisko, Robert M., II	125	Kansas City
Drozda, Joseph P., Jr.	190	Chesterfield
Druck, Norman S.	190	Chesterfield
Druet, Robert L.	082	Springfield
Duckett, William D.	135	Rolla
Duda, Ralph J., Jr.	082	Springfield
Dudik, Randall G.	135	Rolla
Duduzinski, Michelle	125	Kansas City
Duemler, Robert H.	190	Glenco
Duer, Mildred C.	125	Kansas City
Duerksen, Joseph J.	125	Kansas City
Duff, James E.	082	Springfield
Duff, John A.	082	Springfield
Dugan, Gerald F.	125	Kansas City
Duick, Daniel S.	042	Cape Girardeau
Duling, Gerald J.	189	St. Charles
Dumadag, Virgilio P.	190	St. Louis
Duncan, David T.	189	Wentzville
Duncan, Douglas M.	082	Springfield
Dunfield, Jay A.	125	Kansas City
Dunlap, Michael D.	030	St. Joseph
Dunlap, Patrick S.	102	Joplin
Dunn, Charles W.	082	Springfield
***Dunn, Roxanne M.**	030	St. Joseph
Dunshee, Robert E.	158	Maryville
Durel, Justin H.	190	St. Louis
Durnell, Monaford D.	125	Lee's Summit
Durr, Jon W.	190	Florissant
Durrie, Daniel S.	125	Kansas City
Dusek, Dennis A.	190	St. Louis
DuMont, Clement C.	030	St. Joseph
DuMonteer, Gary	074	Washington
DuMontier, Alan J.	190	Chesterfield
Dwyer, Frank X.	125	Prairie Village, KS
Dwyer, James G.	190	St. Louis
Dyer, Curtis W.	110	Warrensburg
Dyer, Dallas J.	190	St. Louis
Dyer, David S.	125	Kansas City
Dyer, Gary A.	030	St. Joseph
Dysart, Dorsey W., Jr.	082	Springfield

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*Elder, Mark J. Springfield	082
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*Ellefsen, Brian K. Carthage	102
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Elliott, Raymond G. Shawnee Mission, KS	125
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Elliott, Wendell H. Poplar Bluff	034
Ellis, Francis J. Springfield	082
Ellis, Harry L. Springfield	082
Ellis, Jean H. Blue Springs	125
Ellis, John C. Independence	125
Ellis, S. Christopher Independence	125
Ellsasser, James C. Rocheport	026
Ellzey, Barbara A. St. Louis	190
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Elwing, Terry J. Columbia	026
Emanuel, James P. St. Louis	190
Emeran, Georges J. St. Louis	190
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Emons, Matthew F. Louisville, KY	190
Engelberg, Alan L. Maryland Heights	190
Engelhardt, Robert C. Poplar Bluff	034
Engels, John T. St. Louis	190
Enriquez, Roman S. Kansas City	125
*Entrup, Mark H. Springfield	082
Eppright, Thomas D. Columbia	026
Epstein, Beverly Mt. Vernon	166
Ernst, Edwin C., Jr. St. Louis	190
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Ernst, Joseph G. St. Louis	190
Ernst, Richard E. St. Louis	190
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Escoffery, Richard F. Florissant	190
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Essah, Paulina A. Kansas City	126
Esther, John R. Joplin	102
Estrem, Scott A. Columbia	026
Ettelson, Charles D. Chesterfield	190
Eubank, David F. Lee's Summit	125
Eubank, William Y. Leawood, KS	125
Evans, Andrew L. Springfield	082
Evans, Ezra L. Springfield	082
Evans, Joseph C., Jr. Independence	125
Evans, Lawrence G., Jr. St. Louis	190
Evans, Maria L. Columbia	026
Evens, Ronald G. St. Louis	190
Eversoll, Norton J. Ft. Lauderdale, FL	190
Ewing, Lesley L. Kansas City	125
Ewy, Marvin F. Columbia	026
Exil, Vernat St. Louis	195
Exon, C. S. Jefferson City	058
Eyen, Thomas P. Overland Park, KS	125
Eyerman, Edward L. St. Louis	190

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Fabito, Daniel C. St. Louis	190
Faddis, Mitchell N. St. Louis	190
Fagan, Leonard F., Jr. St. Louis	190
Fahrner, Mari A. Chesterfield	190
Fair, William L. Chillicothe	078
Fakhoury, Donald A. Kansas City	050
Fallon, Richard H. St. Louis	190
Falzone, John J. Jefferson City	058
Farber, Barry S. Springfield	082
Farberman, Elliott Florissant	190
Farkas, J. Robert Sedalia	178
*Farley, Gary W. St. Louis	190
Farmer, Norma D. Farmington	138
Farnham, Milo M. Independence	125
Farrar, Michael W. Merriam, KS	125
Farrell, John S. Bridgeton	190
Farrell, Sammy L. Washington	074
Farrell, Thomas M. St. Louis	002
Farthing, Gene W. Springfield	082
Faruqi, Sohaib A. Potosi	138
Fast, Robert E. St. Joseph	030
Faszholz, Mark S. Chesterfield	190
Fathman, Anthony E. Chesterfield	190
Faulkner, C. Byron Springfield	082
Favors, Adolphus C., Jr. St. Louis	190
Fedor, Barbara A. Springfield	082
Fedotin, Michael S. Kansas City	125
Fee, Chester F. Overland Park, KS	125
Feit, Robert M. St. Louis	190
Feliciano, Wilfrido C. Maryland Heights	190
Felker, J. Russell Cape Girardeau	042
Feller, Harold H. St. Louis	190
Ferber, Alan J. Kansas City	125
Ferguson, Edward W. St. Louis	190
Ferguson, John F. Springfield	082
Ferguson, John P. Springfield	082
Ferguson, Thomas B. St. Louis	190
Fernandez, Fernando St. Joseph	030
Ferns, Francis E. Kansas City	125
Ferrara, Robert P. St. Louis	190
Ferrari, Herbert A. St. Louis	190
Ferris, Charles W., Jr. St. Louis	190
Fibuch, Eugene E. Kansas City	125
Figueroa, Eliseo O. St. Louis	190
Fingert, Hyman H. St. Louis	190
Fink, Leroy L. St. Louis	190
Fink, Roger L. Rogersville	082
Finkel, Barney W. N. Ft. Myers, FL	190
Finn, Murray E. St. Louis	190

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Finnegan, Joseph V.	St. Louis	190
Fischbein, Lewis C.	St. Louis	190
Fischer, Edward H.	Gladstone	050
Fischer, Heidi	St. Louis	195
Fischer, John R.	Hermann	190
Fischer, Robert	St. Louis	190
Fischer, Ronald L.	Chesterfield	190
Fisher, James K.	Shawnee Mission, KS	125
Fisher, Joseph L.	St. Joseph	030
***Fisher, Robert B.**	Columbia	026
Fishman, Norman	Chesterfield	190
Fitch, Coy D.	St. Louis	190
Fitts, Bill	Nevada	214
Fitz, John R.	Farmington	138
Fitzmaurice, Laura S.	Kansas City	125
***Flanagan, Laura M.**	Olathe, KS	126
Flance, Israel J.	St. Louis	190
Fleer, Gerald K.	St. Peters	189
Fleming, Allan R.	Kansas City	125
Fleming, David A.	Moberly	046
Fleming, J. Will, Jr.	Moberly	046
Fleming, Robert J.	St. Charles	189
Fleshman, James W.	St. Louis	190
Fletcher, Dale M.	St. Louis	190
Fletes, James W.	St. Louis	190
Flicker, Michele R.	Bridgewater, NJ	125
Floerchinger, James S.	St. Louis	002
Florence, Kerry E.	Washington	074
Florendo, Federico N.	Hannibal	150
Florendo, Purificacion T.	Hannibal	150
Flores, Jhonson E.	Chesterfield	190
Floro, Kenneth E., Jr.	St. Louis	190
Floro, Mariano N.	Florissant	190
Flotte, Sylvester A.	St. Louis	190
Floyd, Marla J.	Springfield	082
Fluegel, Wendy L.	Kansas City	125
Flug, Eric J.	St. Louis	190
Flury, Kirk E.	St. Louis	190
Flynn, James M.	Shawnee Mission, KS	125
Fogartie, James E., Jr.	Kansas City	125
Fogarty, William M., Jr.	St. Louis	190
Fogel, Steven T.	Chesterfield	190
Fogle, Philip R.	Springfield	082
Folck, William P.	Kansas City	125
Foley, Jonathon K.	Cape Girardeau	042
Folkner, Albert L.	Warrensburg	110
Foote, Daniel D.	Springfield	082
Foote, Jerry E.	Columbia	026
Forand, Joseph M.	St. Louis	190
Ford, Lee T.	Belleville, IL	190
Ford, Thomas E.	Niagara Falls, NY	190
Foreman, Phillip B.	Hannibal	150
Forgue, Donald R.	Kansas City	125
Forsen, James W., Jr.	St. Louis	002
Forsman, Karen E.	St. Louis	190
Forsman, Waldo W., Jr.	St. Louis	190
Forstot, Robert M.	St. Louis	190
Forsyth, B. Todd	St. Louis	190
Forsythe, Lees C.	Shawnee Mission, KS	125
Forsythe, Robert W.	Prairie Village, KS	125
Fortin, Don G.	Kansas City	050
Fortin, Jorge A.	Rolla	135
Fortuna, Randall S.	St. Louis	195
Foss, Jonathan M.	St. Louis	190
Foster, R. Steve	Sedalia	178
Fouts, Dallas B., Sr.	Lee's Summit	125
Fowler, Fred D.	Kansas City	125
Fowler, I. Charles	Kansas City	050
Fowler, James W.	Leawood, KS	125
Fowler, Marvin L.	West Plains	206
Fox, Gerald E.	St. Joseph	030
Fox, Robert E.	Chesterfield	190
Fox, Thomas J.	St. Louis	190
Francel, Thomas J.	St. Louis	002
Francis, Roger A.	Linn Creek	120
Francisco, Clarence B.	Shawnee Mission, KS	125
Francisco, Dominic S.	St. Louis	190
Franey, Michelle R.	Kansas City	125
Frank, Gael R.	N. Kansas City	125
***Frank, Robert A.**	Independence	125
Fraser, Daniel M.	St. Louis	190
Fraser, Victoria J.	St. Louis	190
Frawley, Thomas F.	Chesterfield	190
Frazier, Robert E.	Columbia	026
***Frederick, Mark R.**	Jefferson City	058
Frederick, Raymond O.	St. Louis	190
Frederickson, Neil W.	St. Louis	190
Frederickson, Robert L.	Sedalia	178
Frederickson, Thomas W.	Prairie Village, KS	126
Freedman, Ruth S.	St. Louis	190
Freeland, Arthur G.	Warrensburg	110
Freeman, James A.	Columbia	026
Freeman, Jerry C.	Kansas City	125
Freeman, Michael R.	Cape Girardeau	042
***Freeman, Steven P.**	Lenexa, KS	126
Freilich, Brad L.	Kansas City	125
Frein, Donald E.	Harrisonville	214
Freund, William L.	N. Kansas City	125
Frevert, Larry F.	Kansas City	125
Frewin, Paul R.	Springfield	082
Fried, John S.	Overland Park, KS	125
Friedman, Ira J.	Washington	074
Friedman, Michael J.	Columbia	026
Friedman, Morris L.	Shawnee Mission, KS	125
Friedman, William H.	St. Louis	190
Friedrich, Anthony P.	St. Charles	190
Friend, T. Gregory	Kansas City	125
Fries, John W.	St. Louis	190
Friesen, Randall G.	St. Charles	189
Fritsch, Andrew J.	Joplin	102
Fritzlen, Thomas J.	Overland Park, KS	125
Froehlich, Thomas W.	Springfield	082
Frogge, Jim D.	Joplin	102
Frohman, Boris	Sikeston	202
Fromme, Glenn A.	Springfield	082
Frumson, Guy H.	Florissant	190
***Fry, John M.**	Ozark	082
Fryer, Dorothy S.	St. Louis	190
Fu, Anna L.	St. Louis	190
Fuchs, George J.	Lake Ozark	026
Fuhrman, Donald L.	Leawood, KS	125
Fullmer, Daniel R.	Overland Park, KS	126
Funsch, Robert E.	St. Louis	190
Furla, August J.	St. Louis	190
Fusselman, Jon M.	Springfield	082

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Gabel, Michael G.	St. Louis	190
Gafarian, Kathleen	Springfield	082
Gaffney, Laura A.	Overland Park, KS	126
Gafford, Franklin H., IV	St. Louis	190
Gagliardo, Joseph	St. Louis	190
Gahn, Richard S.	St. Louis	002
Gaines, Robert W.	Columbia	026
Gainor, Barry J.	Columbia	026
Gaitonde, Mangesh R.	Lee's Summit	026
Galakatos, Andrew E.	St. Louis	190
Galakatos, Gregory R.	St. Louis	190
Galant, Mark R.	Belton	125
Galblum, Larry I.	Kansas City	125
Galbraith, Polly M.	Kansas City	125
Galbreath, Ashford M., Jr.	Kansas City	125
Gale, Arthur H.	St. Louis	190
Gall, Clifford M.	Kansas City	125
Gall, Ira C.	St. Louis	190
Gallemore, Rex A.	Neosho	102
Gallion, Terry L.	Prairie Village, KS	125
Galvez, Sisenando P.	Marceline	078
Gambill, Gary L.	Chesterfield	190

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Gamboa, Edgardo C.	St. Joseph	030
Gandhi, Sanjiv K.	St. Louis	195
Gans, Lawrence A.	Florissant	190
Gantz, John A.	St. Louis	190
Garcia, Delia M.	St. Louis	190
Garcia, Eduardo L.	St. Louis	190
Garcia, Juan C.	St. Louis	190
Garcia, Kathleen M.	St. Louis	190
Garcia, Stephen E.	Springfield	082
Garcia-Ferrer, Eduardo A.	Key Biscayne, FL	190
Gardiner, Robert C.	Kansas City	125
Gardner, Joe A.	Joplin	102
Gardner, Joseph W.	Kimberling City	166
Garfinkel, Bernard T.	St. Louis	190
Garg, Mukesm	Lenexa, KS	126
Garner, James H.	Kansas City	125
Garner, Royal S.	St. Petersburg, FL	058
Garrard, Jacqueline M.	St. Louis	190
Garrett, Ted E.	St. Louis	190
Garrett-Hunt, Christi J.	Kansas City	126
Garriga, Francisco J.	Florissant	190
Garrison, David L.	St. Joseph	030
Garrison, Roy F.	Kansas City	125
Garrison, Theodore W.	Camdenton	120
Garrotto, Lewis J.	Columbia	026
Garvin, Charles F.	St. Louis	190
Gassman, Ann A.	Kansas City	125
Gaston, David A.	Columbia	027
Gatapia, Ramilo I.	Kansas City	126
Gatchalian, Felicitas Z.	St. Louis	190
Gates, Mark L.	Cape Girardeau	042
Gauer, Robert J.	Kansas City	050
Gauthier, Charles P.	Kansas City	125
Gavankar, Sharad S.	Joplin	102
Gavini, Rajendra R.	St. Louis	190
Gay, John W.	Columbia	026
*Gayle, David R.	Piedmont	034
*Gayle, Richard E.	Piedmont	034
Gearhart, Wilbur H.	Ft. Myers, FL	190
Gedney, William B.	Valley Park	190
Gehm, Louis E.	Butler	214
Geier, David L.	Springfield	082
Geisman, Richard A.	St. Charles	189
Geisse, Guillermo C.	St. Louis	190
Gelberman, Richard H.	St. Louis	190
Geller, Bruce D.	Leawood, KS	125
Geller, Robert B.	Kansas City	125
Gellman, Elliot F.	St. Louis	190
Gelstein, Laurence D.	St. Louis	190
Gendel, Jonathan	Lee's Summit	125
Gennaoui, Jad M.	St. Louis	190
Gentle, Donald L.	Cape Girardeau	042
Gentry, Michael A.	Springfield	082
Gentsch, Kenneth W.	St. Louis	190
Genzlinger, Jeffrey L.	Kansas City	126
George, Achenklinju K.	West Plains	206
George, David	St. Louis	195
George, Robert W.	Cape Girardeau	042
Geraghty, Thomas E.	Kansas City	125
Gerdes, John A.	Springfield	082
German, David S.	St. Louis	190
German, Walter A.	Springfield	082
Germann, Donald R.	Shawnee Mission, KS	125
Gernstetter, S. L.	Poplar Bluff	034
Gerowin, Lance	St. Louis	190
Gessler, James A.	Springfield	082
Geter, Rodney K.	Springfield	082
Ghazal-Albar, Naman	Louisiana	150
Gholkar, Vijay R.	Kansas City	125
Ghosh, Nellie	St. Louis	190
Ghosh, Sanjay	Washington	074
Giangiacomo, Joseph	Columbia	026
Gibbons, James J.	St. Louis	190
*Gibbons, Jerry L.	St. Louis	190
Gibbons, Robert T., Jr.	Overland Park, KS	125
Gibson, David M.	Santa Fe, NM	125
Gibson, James D.	Springfield	082
Gibson, Merlyn D.	Columbia	026
Gibson, Paul H.	St. Louis	190
Gibson, William P.	Chesterfield	190
Giddings, Frank C.	Springfield	082
Gieselmann, James W.	Poplar Bluff	034
Giessel, Barton	Columbia	027
*Giffen, Lawrence E.	Jefferson City	058
Gigantelli, James W.	Columbia	026
Gilbirds, William M., II	Kansas City	050
Gilden, Jerome J.	St. Louis	190
Gill, Paul J.	Springfield	082
Gilliland, Craig	Kansas City	002
Gilula, Louis A.	St. Louis	190
Gimpelson, Richard J.	Chesterfield	190
Ginardi, Donald E.	Kansas City	125
Ginsberg, B. William	Kansas City	125
Ginther, James W., Jr.	St. Louis	190
Giorgi, Lee V.	Kansas City	125
Gish, E. R.	Fulton	038
Givler, Robert L.	Kansas City	125
Glaser, Dee Anna	St. Louis	002
Glaser, Larry F.	Cleveland	125
Glass, William J.	Nixa	166
Glazer, Harvey S.	St. Louis	190
Glazer, Melvin L.	Kansas City	125
Glenn, Edward A.	Louisiana	150
Glenn, Theodore J.	Cape Girardeau	042
Glenski, James A.	Kansas City	125
Glines, Michael H.	Arnold	190
Glotzbach, Ellen S.	Kansas City	125
Glover, David	Warrensburg	110
Glueck, Robert M.	Kansas City	125
Gnade, Albert J.	St. Louis	190
Gnatz, Steven	Columbia	026
Godlewski, Krystof J.	Kansas City	125
Godwin, Lehman W.	Springfield	082
Goebel, Joel A.	St. Louis	190
Goeking, C. Keith	St. Joseph	030
Goff, John E.	Joplin	102
Goheen, John R.	Kansas City	125
Gold, Jonathan A.	St. Louis	190
Goldberg, Joseph P.	Mentor, OH	125
Goldfarb, Charles	St. Louis	195
Goldman, Arnold M.	St. Louis	190
Goldman, Barry C.	Kansas City	125
Goldman, Gordon M.	St. Louis	190
Goldman, Stanley L.	Shawnee Mission, KS	125
Goldring, Sidney	St. Louis	190
Goldsich, Edward	Kansas City	125
Goldstein, David E.	Columbia	026
Goldstein, Marcy A.	St. Louis	002
Goldstein, Marvin F.	Kansas City	125
Goler, Michael R.	Springfield	082
Goltschman, John P.	Florissant	190
Gomez, Cesar A.	St. Louis	190
Gomez, Patrick L.	Springfield	082
Gondring, William H.	St. Joseph	030
Gonzales, Jose H.	Perryville	174
Gonzalez, Alicia D.	St. Louis	190
Gonzalez, Federico	Shawnee, KS	125
Good, Michael W.	Springfield	082
Good, Thomas H.	Kansas City	125
Goodenberger, Daniel M.	St. Louis	190
Goodhope, Karen F.	St. Louis	190
Goodman, Gary M.	Chesterfield	190
Goodrich, Steven D.	Florissant	190
Goodwin, J. Wendall	Springfield	082
Gordon, Bruce J.	Columbia	026
Gordon, Glenn L.	Mexico	014
Gordon, James M.	Florissant	190
Gordon, James S.	Sedalia	058

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Gordon, Mark E.	**050**	N. Kansas City
Gose, Don F.	**082**	Springfield
Gosek, Marek J.	**110**	Warrensburg
Gottsch, Joseph C.	**125**	Shawnee Mission, KS
Gould, Ronald J.	**190**	St. Louis
Gowda, Manohar Sai	**126**	Shawnee, KS
Gowdamarajan, Rengasamy	**125**	Kansas City
Grable, James D.	**042**	Cape Girardeau
Grady, Ronald K.	**190**	Chesterfield
***Graessle, Donna M.**	**125**	Shawnee, KS
Graff, Ralph J.	**190**	St. Louis
Graham, Bruce D.	**125**	Shawnee Mission, KS
Graham, Joseph E.	**190**	St. Louis
Graham, Patrick G.	**125**	N. Kansas City
Granberg, Steven J.	**190**	St. Louis
Grand, M. Gilbert	**190**	St. Louis
Grandstaff, P. Matthew	**125**	Prairie Village, KS
Grant, Laura L.	**026**	Columbia
Grant, Mark	**026**	Columbia
Grant, Neville	**190**	St. Louis
Grant, Ruth	**082**	Springfield
Graul, Walter P.	**190**	St. Louis
***Graven, Timothy G.**	**106**	De Soto
Graviss, E. Richard	**190**	St. Louis
Gray, Gary J.	**190**	St. Louis
Gray, Scott E.	**082**	Springfield
Grechus, John J.	**138**	Farmington
Greco, Thomas J.	**190**	St. Louis
Greditzer, Harry G., III	**190**	St. Louis
Green, J. Richard	**125**	Independence
Green, Morton R.	**190**	Belleville, IL
Green, Thomas F.	**125**	Independence
Green, William R.	**190**	St. Louis
Greenberg, Jeffrey A.	**102**	Joplin
Greene, Harry L.	**150**	Tucson, AZ
Greene, Howard G.	**150**	Louisiana
Greene, Walter B.	**026**	Columbia
Greenlaw, Cal W.	**078**	Chillicothe
Greenlund, Nelson C.	**214**	Nevada
Greenspan, Aaron B.	**195**	St. Louis
***Greenspan, Peter B.**	**125**	Independence
***Greer, Sam T.**	**102**	Joplin
Gregory, Mark H.	**190**	St. Louis
Gregston, J. Leon	**082**	Springfield
Gresick, Robert J.	**190**	St. Louis
Gresick, Robert J., Jr.	**190**	St. Louis
Griesbaum, Robert V.	**190**	St. Louis
Griesemer, Bernard A.	**082**	Springfield
Griffin, Darrell L.	**138**	Farmington
Griffin, Donald R.	**002**	Kansas City
Griffin, M. E.	**066**	Springfield
Griffin, William T.	**026**	Columbia
Griffith, S. Kent	**042**	Cape Girardeau
Grigsby, Perry W.	**190**	St. Louis
Grillot, Michael B.	**082**	Springfield
Grim, Edward M.	**102**	Joplin
Grimes, Manning E.	**030**	St. Joseph
Grimes, R. Alan	**126**	Kansas City
Grimm, Mark E.	**082**	Springfield
Grimm, Mary T.	**190**	Florissant
Grindlinger, Howard M.	**034**	Poplar Bluff
Grisham, Thomas D.	**074**	Washington
Groce, George D.	**038**	Fulton
Groll, John R.	**190**	St. Louis
Groshong, Ted D.	**026**	Columbia
Grossberg, George T.	**190**	St. Louis
Grubb, Michael M.	**102**	Joplin
Grubb, Robert L., Jr.	**190**	St. Louis
Gruenebaum, Steven A.	**125**	Kansas City
Grunt, Jerome A.	**125**	Kansas City
***Gryte, Rolf R.**	**120**	Osage Beach
Guastello, Joseph R.	**125**	Kansas City
Guastello, Mario J.	**125**	Kansas City
Gubin, Barry A.	**125**	Kansas City
Guerra, Gaston G.	**125**	Kansas City
Guhleman, Henry V.	**058**	Jefferson City
Guinn, O. Allen, III	**125**	Independence
Gujarati, Subhash B.	**034**	Poplar Bluff
Gulick, C. Richard	**190**	St. Louis
Gum, Patricia A.	**195**	Belton
Gunderson, Jeffrey K.	**082**	Springfield
Gunn, Jack	**120**	Versailles
Gunn, Richard W.	**125**	Kansas City
Gunn, Victoria	**058**	Jefferson City
Gunnoe, Robert E.	**125**	Kansas City
Gunter, Joe S.	**030**	Lawrence, KS
Gunter, Kevin G.	**178**	Sedalia
Gupta, Nilakshi	**026**	Columbia
Gupta, Vicram	**030**	St. Joseph
Gurba, Carol L.	**125**	Kansas City
Gurba, Danny M.	**125**	Kansas City
Gurian, Lawrence E.	**082**	Springfield
Gurucharri, Vincent P.	**026**	Columbia
Gustafson, Jon E.	**125**	Lee's Summit
Gutek, E. Philip	**125**	Kansas City
Gutierrez, Ernesto	**190**	Florissant
Gutknecht, Richard	**125**	Independence
Guy, Cynthia S.	**190**	St. Louis
Guyer, Emily	**026**	Columbia
Guyol, William B., Jr.	**190**	St. Louis
Guze, Samuel B.	**190**	St. Louis
Gwin, Edward	**082**	Springfield

H

Ha, Richard J.	**150**	Hannibal
Haake, Gregory K.	**082**	Springfield
Haas, Robert W.	**050**	Liberty
Habermann, James H.	**102**	Joplin
Habert, Edward R.	**190**	Chesterfield
Habib, Ahmed A.	**026**	Columbia
Habib, Henry N.	**120**	Sterling, VA
Hackett, Earl R.	**082**	Springfield
Haddock, James N.	**190**	St. Louis
Haddow, Alastair D.	**082**	Springfield
Hagan, John C., III	**050**	N. Kansas City
Hagan, Phillip F.	**050**	Liberty
Hagemann, Margarethe H.	**190**	St. Louis
Hagemann, Paul O.	**190**	St. Louis
Hagen, Douglas W.	**125**	Kansas City
Hagen, Duane Q.	**190**	St. Louis
Hagen, Garrett A.	**190**	St. Louis
Hahn, Bruce H.	**125**	Lee's Summit
Hahn, Frederick W.	**125**	Independence
Hahn, Yoram	**190**	Florissant
Haight, J. Max	**125**	Kansas City
Hainsworth, Dean P.	**026**	Columbia
Haith, Walter F.	**125**	Kansas City
Halberstadt, Cathanie W.	**125**	Kansas City
Hale, Thomas H.	**190**	Manchester
Haleem, Usman	**195**	St. Louis
Hall, David G., III	**026**	Rocheport
Hall, Deborah M.	**125**	Overland Park, KS
Hall, Durward G.	**082**	St. Petersburg, FL
Hall, John C.	**125**	Kansas City
***Hall, John P.**	**042**	Cape Girardeau
Hall, Robert T.	**125**	Kansas City
Hall, Stanley G.	**150**	Hannibal
Hall, Terry E.	**078**	Bethany
Halloran, Mark J.	**190**	St. Louis
Halpin, Stephen E.	**150**	Hannibal
Halsted, Robert W.	**074**	Washington
Halsted, Teresa M.	**074**	Washington
Halverson, Larry W.	**082**	Springfield
Ham, Kevin R.	**034**	Poplar Bluff
Hamburg, Eric D.	**138**	Farmington
Hamburg, Mitchell S.	**125**	Kansas City
Hamel, Peter C.	**150**	Hannibal
Hamid, Rashid S.	**198**	Marshall
Hamid, Zahid	**158**	Mound City

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Hamill, Robert W.	Gulfport, FL	**125**
Hamilton, Caldwell K.	St. Louis	**190**
Hamilton, Eugene G.	St. Louis	**190**
Hamilton, William P.	Aurora	**166**
Hamilton, William P.	St. Louis	**190**
Hammerman, Marc R.	St. Louis	**190**
Hammond, Billy A.F.	Cape Girardeau	**042**
Hammond, D. Wade	St. Louis	**190**
Hanaway, Joseph	St. Louis	**190**
***Hancock, Thomas J.**	Jefferson City	**058**
Handler, Barry	St. Louis	**195**
Handler, Fred P.	Clayton	**058**
Handler, Michael R.	St. Louis	**190**
***Handlin, Larry R.**	Mexico	**014**
Hanes, Lily A.	Golden Eagle, IL	**190**
Hanks, Michael S.	Springfield	**082**
Hanley, Thomas P.	St. Louis	**190**
Hanna, Hugh A.	Warrensburg	**110**
Hannah, Hamner, III	Prairie Village, KS	**125**
Hannas, Ralston R.	Kansas City	**125**
Hansbrough, Eugene T.	Poplar Bluff	**034**
Hansen, Thomas L.	Independence	**125**
Hanson, E. J.	Kansas City	**125**
Hanson, Jason M.	Valley Park	**195**
Hanson, Karl H.	Kansas City	**125**
Hanson, Morin M.	St. Louis	**190**
Hantz, Oscar	Florissant	**190**
Hardacre, Ruth A.	Kansas City	**125**
Hardin, William B., Jr.	Manchester	**190**
Harding, Clarke T.	Collinsville, IL	**189**
Hardy, David A.	St. Louis	**190**
Hardy, Guerdan	St. Louis	**190**
Hardy, H. Malcolm	Shawnee Mission, KS	**125**
Hardy, Jeffery A.	St. Louis	**190**
Hardy, Patrick J.	Florissant	**190**
Hardy, Samuel W.	St. Louis	**190**
Hardy, Stanton L.	Desloge	**138**
***Hare, Thomas**	Springfield	**082**
Harell, Alex	St. Louis	**190**
Hargis, James L.	Springfield	**082**
Hari, Magaral S.	Joplin	**102**
Harless, Morris S.	Galena	**125**
Harmon, Ben C.	Springfield	**082**
Harms, James F.	Nevada	**214**
Harner, Casper G.	Austin, TX	**030**
Harr, Patrick B.	Maryville	**158**
Harris, David J.	Kansas City	**125**
Harris, Hugh G.	Springfield	**082**
Harris, Hugh S., Jr.	Columbia	**026**
Harris, Lanny W.	Kansas City	**125**
Harris, Louis B.	Bolivar	**066**
Harris, Weldon L.	Independence	**125**
***Harris, William D.**	Lenexa, KS	**125**
Harrison, Garth F.	Kansas City	**125**
Harrison, Thomas J., Jr.	St. Charles	**189**
Harrison, Winston E.	Columbia	**026**
Harshman, David M.	St. Louis	**190**
Hart, L. Wayne	Shawnee Mission, KS	**125**
Hart, William G., Jr.	St. Louis	**190**
Hart, William M., Jr.	St. Louis	**190**
Hartman, James M.	St. Louis	**190**
Hartman, Paul T.	St. Louis	**190**
Hartman, Richard A.	St. Louis	**190**
Hartnett, Anna E.	Clayton	**190**
Hartnett, Thomas D.	St. Louis	**190**
Hartstein, Jack	Chesterfield	**190**
Hartwig, Frederick H.	Kansas City	**125**
Hartwig, Raymond W.	Kansas City	**125**
Hartzler, Geoffrey O.	Shawnee Mission, KS	**125**
Harvey, Judith E.	Springfield	**082**
Harwell, J. Larry	St. Louis	**190**
Haskins, Robert D., Jr.	Springfield	**082**
Hassen, Mark A.	St. Louis	**002**
Hassien, Joel D.	Hannibal	**150**
Hata, J. Steven	Columbia	**026**
Hata, Tara M.	Columbia	**026**
Hatfalvi, Bela I.	St. Louis	**190**
Hatlelid, J. Michael	St. Louis	**190**
Haulard, Marcel E.	Wright City	**190**
Haupt, Herbert A.	St. Louis	**190**
Hauser, Robert J.	Jefferson City	**058**
Havey, John	Columbia	**026**
Havlioglu, Necat S.	St. Louis	**190**
Hawatmeh, Abraham S.	St. Louis	**190**
Hawatmeh, Isam	St. Louis	**190**
Hawk, Bray O.	St. Louis	**190**
Hay, Donald P.	St. Louis	**190**
Haybron, David M.	Columbia	**026**
Haycraft, Gordon L.	Cape Girardeau	**042**
Hayden, Melvin R.	Camdenton	**120**
Hayek, Michael E.	St. Louis	**190**
Hayes, Kimberly W.	Lee's Summit	**125**
Hayes, Lawrence L.	Kansas City	**050**
Hayes, Nancy J.	Mountain Grove	**206**
Haynie, William W.	Butler	**214**
Hazan, Joseph	Bridgeton	**190**
Hazen, Robert M.	Prairie Village, KS	**125**
Hazuka, David F.	Shawnee Mission, KS	**125**
H'Doubler, Charles	Mt. Vernon	**082**
H'Doubler, Francis T.	Springfield	**082**
H'Doubler, Peter B.	Springfield	**082**
Headrick, John A.	Lake St. Louis	**190**
Healy, Brian E.	Kansas City	**002**
Heath, Jimmy D.	East Prairie	**202**
***Hechler, Mark L.**	Warrensburg	**110**
Hecht, Brian S.	Columbia	**026**
Hecker, Joseph E.	Poplar Bluff	**034**
Hedgepeth, Bruce L.	Springfield	**082**
Hedrick, Frances A.	Holts Summit	**058**
Heeb, Max A.	Sikeston	**202**
Hegde, Korgi V.	St. Louis	**190**
Hegde, S. Roy	Kansas City	**125**
Heimburger, Richard A.	Osage Beach	**120**
Heins, James N.	St. Louis	**190**
Heise, Julie R.	Liberty	**125**
Helfrich, Loring	Sikeston	**202**
Helikson, Mary A.	Columbia	**026**
Hellam, Duane C.	Springfield	**082**
Heller, Randall L., Jr.	St. Louis	**190**
Helling, Thomas S.	Kansas City	**125**
Hellman, Richard	N. Kansas City	**125**
Hellweg, Raymond W.	Florissant	**190**
Helzberg, John H.	Kansas City	**125**
Hembree, Kathryn A.	Liberty	**050**
Hendren, Thomas H.	Liberty	**050**
Henry, Clarke L.	Shawnee Mission, KS	**125**
Henry, Clarke L., Jr.	Kansas City	**125**
Henry, Joseph E.	Shawnee Mission, KS	**050**
Henry, Lawrence D.	Columbia	**058**
Henry, Mary M.	Kansas City	**125**
Henry, R. Beth	Kansas City	**125**
Henson, Bruce E.	Kansas City	**125**
Henson, Robert E., II	St. Louis	**195**
Herdoiza, Alfonso W.	Shawnee Mission, KS	**125**
Herfkens, Kenneth D.	Springfield	**082**
Herman, Robert L.	Kansas City	**125**
Hernandez, J. Humberto	Gerald	**074**
Hernandez, Richard P.	Cape Girardeau	**138**
Hernandez, Salvador R.	St. Louis	**190**
Herold, Robert E.	St. Charles	**189**
Herrick, Thomas B.	Kansas City	**050**
Herrmann, Deborah A.	Marshall	**198**
Herrmann, Joseph G.	Des Peres	**195**
Herrmann, Steven C.	High Ridge	**195**
Hershey, Falls B.	St. Louis	**190**
Hervey, William H.	Kansas City	**125**
Herzog, Godofredo M.	Florissant	**190**
Herzog, Jacques A.	Chesterfield	**190**

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Hesker, Albert E.	190	Chesterfield
Hess, John P.	190	St. Louis
Hess, L. Wayne	026	Columbia
Hettinger, Brenda A.	120	Camdenton
Heutel, Lee B.	190	St. Louis
Hickey, James L.	190	St. Louis
Hicks, Christina M.	027	Fulton
Hicks, Frederick G.	190	St. Louis
Hicks, Robb R., IV	042	Cape Girardeau
Hierholzer, Rebecca S.	125	N. Kansas City
Higginbotham, Dennis G.	206	West Plains
Higgins, Edward F., Jr.	125	Kansas City
Higgins, Michael D.	042	Cape Girardeau
Higgins, Philip C.	190	St. Louis
Higgins, Ronald A.	125	Kansas City
Higgs, Philip E.	190	St. Louis
Highland, Thomas R.	026	Columbia
Hilbert, Paul H.	190	St. Louis
Hill, David K.	125	N. Kansas City
Hill, Jack H.	125	Leawood, KS
Hill, M. Robert	190	St. Louis
Hill, Michael L.	102	Joplin
Hill, Randy C.	082	Springfield
Hill, Ronald T.	202	Dexter
Hill, XaCadene A.	190	St. Louis
Hillard, Alan E.	026	Columbia
Hills, Joe E.	082	Springfield
Hilton, Paul E.	102	Joplin
Hinds, R. David	026	Columbia
Hindupur, Mohan R.	030	St. Joseph
Hinrichs, Christian S.	126	Kansas City
Hinrichs, James H.	190	Bridgeton
Hinshaw, Kevin D.	190	St. Louis
Hinson, Gary W.	125	Overland Park, KS
Hintze, Paul F.	190	Chesterfield
Hiremath, Yoganand J.	102	Joplin
Hironimus, John E.	190	St. Louis
Hirose, Christopher B.	195	St. Louis
Hite, Dennis E.	115	Lebanon
Ho, Judith E.	190	St. Louis
Hoberock, Thomas R.	208	Branson
Hodge, Robert H.	050	Kansas City
Hoech, George P., Jr.	125	Kansas City
Hoehn, John P., III	190	St. Louis
Hoehner, Paul J.	030	St. Joseph
Hoeman, Michael D.	082	Springfield
Hoeper, Samuel D., Jr.	125	Kansas City
Hoeper, Samuel D., Sr.	125	Grandview
Hoffarth, Sharon C.	190	St. Louis
***Hoffman, James E.**	042	Cape Girardeau
Hoffman, Leanna M.	078	St. Joseph
Hoffman, Mark J.	190	St. Louis
Hoffman, William F.	190	St. Louis
Hoffmann, Alan L.	125	Kansas City
Hoffmann, Lee M.	125	Shawnee Mission, KS
Hoffmann, Ronald E.	190	St. Louis
Hoffmann, Sandra S.	190	Chesterfield
Hofmeister, Roger W.	026	Columbia
Hofstatter, Leopold	190	St. Louis
Hogan, Cornelius E.	190	St. Louis
Hogan, John R.	190	St. Louis
***Hogan, Patricia E.**	030	St. Joseph
Hogan, Patrick A.	190	St. Louis
Hogan, Patrick C.	190	St. Louis
Hoja, John M.	034	Poplar Bluff
Hoja, W. Alex	034	Poplar Bluff
Holand, Roy W.	082	Springfield
Holcomb, John K.	042	Cape Girardeau
Holder, Thomas M.	125	Prairie Village, KS
Holds, John B.	190	St. Louis
Holekamp, Timothy	026	Columbia
Holemon, R. Eugene	190	St. Louis
Holkins, John M.	125	Kansas City
Holley, Donald B.	082	Springfield
Hollis, Richard W.	082	Springfield
Hollocher, Richard J.	190	St. Louis
Holloman, Walter G.	190	Ballwin
Holloway, Robert B.	190	St. Louis
Holmes, David R.	082	Springfield
Holmes, Nancy E.	190	St. Louis
Holt, Benjamin T.	026	Columbia
Holtmann, Barbel	190	St. Louis
Holton, Edward B.	125	Independence
Holtz, Alan S.	190	St. Louis
Holtz, Sumner	002	Chesterfield
Holzem, Craig S.	074	Washington
Honaas, Trygve O.	042	Cape Girardeau
Honeycutt, Pamela J.	026	Columbia
Honickman, Neal A.	042	Cape Girardeau
Hoos, Gary L.	082	Springfield
Hooshmand, Ahmad	058	Jefferson City
Hoover, Bernard L.	190	St. Louis
Hopkins, James P.	125	Shawnee Mission, KS
Hopkins, Thomas S.	178	Hughesville
Hopson, David K.	190	St. Charles
Horan, John J., Jr.	190	St. Louis
Horenstein, Simon	190	St. Louis
Horine, Jon A.	125	Kansas City
Horn, Paul C.	042	Cape Girardeau
Hornbostel, Phillip M.	178	Sedalia
Horner, Charles W.	125	Kansas City
Horner, John L.	190	Chesterfield
Hornig, Gregory W.	125	Kansas City
Hornstra, Robijn K.	125	Kansas City
Horton, Bill G.	082	Springfield
Horton, James D.	082	Springfield
Horton, John H.	125	Leawood, KS
Hoskins, R. Bruce	125	Kansas City
***Hosley, Brett D.**	150	Hannibal
Houck, William E.	190	Chesterfield
Houghton, Howard L.	125	Kansas City
Houttuin, Erik	074	Washington
Hover, Alexander R.	082	Springfield
Howard, Campbell P.	125	Kansas City
Howard, Todd K.	190	St. Louis
Howell, Billy D.	078	Brookfield
Howell, David T.	002	Florissant
Howitt, William J.	082	Springfield
Hoxworth, Gerald M.	135	Belle
Hoye, Robert C.	174	Ste. Genevieve
Hrabik, Brent	158	Tarkio
Hruza, George J.	190	St. Louis
Hruza, Luciann L.	002	St. Louis
Hu, Raymond J.	189	St. Peters
Hubbard, John D.	125	Kansas City
Hubbard, Sally L.	082	Springfield
Hubbell, George P.	120	Osage Beach
Hubbell, Marius M., Jr.	125	Kansas City
Huber, Kenneth C.	125	Kansas City
Hubert, John W.	190	Bridgeton
Huck, Richard F., Jr.	190	St. Louis
Hucke, Samuel T., III	125	Kansas City
Huddleston, Charles B.	190	St. Louis
Hudgens, Richard W.	190	St. Louis
Hudson, Randall B.	125	Kansas City
Huewe, Douglas A.	082	Springfield
Huff, Kalaichelvi R.	102	Joplin
Huffaker, William H.	190	St. Louis
Huffman, Larry	208	Branson West
Huggins, Albert M.	190	St. Louis
Hughes, Derek	026	Columbia
Hughes, Michael F.	125	Kansas City
Huguenard, Joseph R.	190	St. Louis
Huk, Stephen G.	050	Overland Park, KS
Hulbert, Bernard	190	St. Louis
Hulbert, Laura R.	190	St. Louis
***Hull, Jeffrey F.**	125	Kansas City
Hull, Timothy A.	125	Kansas City

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Hulstra, Johannes F.	082	Springfield
Hummel, Anton J.	190	St. Louis
Hummel, Gregory L.	125	Independence
Humphrey, James D.	158	Mound City
Humphrey, Loren J.	026	Columbia
Humphrey, Paul W.	026	Columbia
Humphreys, Edward T.	026	Boonville
Humphreys, William	030	St. Joseph
Hunkeler, John D.	125	Kansas City
Hunleth, Frank E.	190	St. Louis
Hunsley, Perry U.	208	Salina, KS
Hunt, Robert S.	042	Cape Girardeau
***Hunter, Harlen C.**	190	Chesterfield
Hunter, James K., Jr.	158	Fairfax
Hunzicker, Warren J.	125	Kansas City
Hurley, Joseph J.	190	St. Louis
Hurly, Michael P.	102	Joplin
Huse, William J., II	125	Kansas City
Huss, Randall D.	135	Rolla
Husted, Frederick C.	082	Springfield
Huster, Robert M.	135	Liberty
Huston, Kent A.	125	Kansas City
***Hutchins, Sherry S.**	135	Waynesville
Hutchinson, William B.	190	St. Louis
Hyatt, Robert W.	058	Jefferson City
Hyde, Lawrence L.	125	Kansas City

I

Icaza, Ramiro	042	Jackson
Ide, Carl H.	026	Columbia
Idstrom, Mark E.	125	Kansas City
Imes, Elvin D.	026	Columbia
Inciardi, Marc F.	125	Leawood, KS
Ingham, Walton C.	125	Shawnee Mission, KS
Ingram, Donald R.	190	Festus
Ingram, Ellis A.	026	Columbia
Inman, Max M.	190	Chesterfield
Inocentes, Fe A.	189	O'Fallon
Ip, Aidan W.	190	St. Louis
Irvin, William M.	190	St. Louis
Irvin, William S.	026	Columbia
Isaac, Anita M.	082	Springfield
***Isaacs, Victor E.**	042	Scott City
Ishida, Yasuo	190	St. Louis
Itoku, Kendall A.	190	Chesterfield
Ivins, Gregory K.	038	Fulton
Iwane, Akira	190	Chesterfield
Izmirlian, Grant	190	St. Louis

J

Jaax, Jeffrey D.	125	Kansas City
Jablonski, Raymond C.	190	St. Charles
Jackson, Dorothy J.	125	Kansas City
Jackson, Jay A.	125	Kansas City
Jackson, Mary Anne	002	Kansas City
Jackson, Max G.	125	Kansas City
Jackson, Roger P.	050	Kansas City
Jackson, Vernon B.	038	Fulton
Jacob, Joe	026	Columbia
Jacob, Karl A.	190	St. Louis
Jacobs, Donald L.	002	St. Louis
Jacobs, Morton	125	Overland Park, KS
Jacobson, Jill D.	125	Kansas City
Jaeger, Joseph N.	042	Jackson
Jafri, Syed F.	078	Hamilton
Jain, Poonam M.	190	Ballwin
Jain, Sandeep	195	St. Louis
Jain, Savitri G.	190	St. Louis
Jain, Sumer C.	190	St. Louis
Jain-Roberts, Sangeeta	058	Jefferson City
Jakoby, Michael G., IV	190	St. Louis
Jamal, Ayman	126	Kansas City
James, Elizabeth J.	026	Columbia
James, Kathleen M.	189	St. Charles
James, Kelly M.	125	Independence
James, Otis E.	125	Shawnee Mission, KS
James, Paul M., Jr.	038	Fulton
James, Ronald C.	026	Columbia
Jameson, James E.	082	Springfield
Jamison, Kimberly	026	Columbia
Jamroz, Greg A.	074	Washington
Janeczko, Gregory F.	082	Springfield
Janney, Stephen K.	190	St. Louis
Jantsch, Deborah A.	125	Kansas City
Jantz, Keith	125	Kansas City
Jarka, Dale E.	125	Kansas City
Jarvis, Cathy C.	190	Florissant
Javdan, Ron	190	St. Louis
Jayamanne, Damasus S.	058	Jefferson City
Jedlinski, Michael T.	042	Cape Girardeau
Jeffries, Joel T.	026	Columbia
Jenkins, David C.	125	Kansas City, KS
Jenkins, Edward R.	135	Waynesville
Jenkins, James J.	190	St. Louis
Jennett, Richard B.	058	Jefferson City
Jensen, Joshua E., II	190	St. Louis
Jessup, Michael J.	042	Cape Girardeau
Jew, Amie C.	125	Overland Park, KS
Jewell, Gregory L.	190	St. Louis
Jimenez, David F.	026	Columbia
Jobe, Charles L.	082	Springfield
Johar, Ravi S.	190	St. Louis
Johnson, Annette J.	195	St. Louis
Johnson, C. L.	125	Kansas City, KS
Johnson, Charles J.	190	St. Louis
Johnson, Cindi K.	030	St. Joseph
Johnson, Dallas A.	125	Overland Park, KS
Johnson, Earl W.	042	Cape Girardeau
Johnson, Eric J.	002	Chesterfield
Johnson, Frank E.	002	St. Louis
Johnson, Fritz M.	082	Springfield
Johnson, Gareth R.	125	Independence
Johnson, Garry A.	190	Des Peres
Johnson, Glen E.	190	St. Louis
Johnson, Gordon L.	106	Festus
Johnson, James S.	125	Kansas City
Johnson, Jeffrey R.	082	Springfield
Johnson, Joseph C., Jr.	082	Springfield
Johnson, Joseph E.	125	Kansas City
Johnson, Lent C.	150	Hannibal
Johnson, Lenworth N.	026	Columbia
Johnson, Patrick E.	138	Farmington
Johnson, Rebecca S.	125	Kansas City
Johnson, Robert D.	082	Springfield
Johnson, Steven M.	190	Clayton
Johnson, Thomas M.	125	Shawnee Mission, KS
Johnson, Warford B., Sr.	082	Springfield
Johnson, Warford B., II	082	Springfield
Johnson, Warren L., Jr.	125	Kansas City
Johnston, Richard	190	St. Louis
Johnstone, John T.	190	St. Louis
Jolly, Ben L.	014	Mexico
Jolly, Benjamin N.	014	Mexico
Jonas, Harry S.	125	Chicago, IL
Jones, Bruce N.	190	Chesterfield
Jones, Dwayne E.	125	Shawnee, KS
Jones, Edward S.	214	Overland Park, KS
Jones, Gale O.	125	Kansas City
Jones, Georgia A.	190	St. Louis
Jones, Gordon	202	Sikeston
Jones, Harold L.	082	Springfield
Jones, Jeffrey T.	102	Joplin
Jones, Justin E.	014	Mexico
Jones, Laird E.	082	Springfield
Jones, Lowry, Jr.	125	Kansas City
Jones, Maynard C., Jr.	125	Lee's Summit
Jones, Michael D.	014	Mexico
Jones, Paul S.	102	Joplin
Jones, Randall W.	125	Independence
Jones, Richard A.	190	St. Louis

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Jones, Robert P.	125	Blue Springs
Jones, Robert R.	214	Nevada
Jones, Robert W.	206	West Plains
Jones, Robin R.	026	Columbia
Jones, T. Reid	125	Prairie Village, KS
Jones, Timothy R.	190	St. Louis
***Jordan, Earl L., Jr.**	102	Joplin
Jordan, L. Keith	027	Columbia
Jorgensen, Eric D.	026	Columbia
Joseph, Harold J.	190	St. Louis
Joshi, Surekha K.	190	St. Louis
Joslyn, Harold L.	190	Mt. Vernon, IN
Jost, Charles A.	190	N. Ft. Myers, FL
Josyula, Bhagavan V.	002	St. Louis
Jotte, Richard P.	190	St. Ann
Jotte, Richard F.	190	St. Louis
***Joubert, Paul M.**	125	Lee's Summit
Joyce, Steven T.	125	Kansas City
Judd, Donald R.	190	St. Louis
Judd, Jeffrey B.	190	St. Louis
Judge, Steven J.	074	Washington
Judy, Joseph D.	026	Beloit, WI
Juergens, William G.	190	St. Louis
Julien, Rene L.	190	Belleville, IL
Jung, Christopher H.	042	Cape Girardeau
Jung, J. Marshall	042	Cape Girardeau
Junker, James A.	106	St. Louis
Justus, John B.	125	Shawnee Mission, KS

K

Kairuz, Bartolome C.	190	St. Louis
Kaiser, George C.	190	St. Louis
Kakaiya, Dilip H.	070	Kennett
Kalahasthy, Kalpana R.	126	Kansas City
Kallenbach, Glen P.	014	Mexico
Kamakas, Nicholas C.	190	St. Louis
Kamath, K.P.S.	042	Cape Girardeau
Kamenetzky, Stephen A.	190	St. Louis
Kanagawa, Harold K.	058	Jefferson City
Kanarek, Henry L.	125	Kansas City
Kanarek, Joseph	125	Kansas City
Kandula, Madhavi	190	St. Louis
Kang, Juan	190	St. Louis
Kang, Young M.	206	West Plains
Kanne, Marty A.	050	Kansas City
Kantor, Julius M.	125	Mission Hills, KS
Kantor, Owen	190	St. Louis
Kantor, Samuel	125	Englewood, CO
Kaplan, Henry J.	190	St. Louis
Kaplan, Michael F.	026	Columbia
Kapp, Dave	174	Perryville
Kapp, Mary Beth	042	Cape Girardeau
Kapp, William K., III	042	Cape Girardeau
Kappesser, Netajean G.	190	St. Louis
Kappesser, Roland C.	190	St. Louis
Kardesch, Milton	190	St. Louis
Karges, Melvin D.	125	Joplin
Karl, Michael M.	190	St. Louis
***Karr, Jerry L.**	042	Cape Girardeau
Karraker, Alvan G.	138	Farmington
Karsh, Robert S.	190	St. Louis
Kartis, Thomas, Jr.	102	Joplin
Kartus, Irving	125	Shawnee Mission, KS
Kase, James B., Jr.	125	N. Kansas City
Kass, Michael A.	190	St. Louis
Kasten, Mark C.	042	Cape Girardeau
Kasten, Melvin C.	042	Cape Girardeau
Kaster, Steven D.	125	Kansas City
Katf, Nicola Y.	050	N. Kansas City
Katragadda, Rajsndra P.	002	Kansas City
Katsantonis, George	190	St. Louis
Katsiyiannis, William	195	St. Louis
Kauffman, Ruth	120	Versailles
Kaufman, Andrew B.	125	Kansas City
Kaufman, Bruce A.	190	St. Louis
Kaufman, Robert L.	190	St. Louis
Kaufmann, Herbert H.	125	Shawnee Mission, KS
Kauk, Bruce A.	050	N. Kansas City
Kaup, Chandra S.	190	Florissant
Kayanan, Jose C.	125	Kansas City
Kayes, Jack	190	St. Louis
Kays, Kenneth M.	046	Osage Beach
Keairnes, Harold W.	125	Kansas City
Keefe, David M.	189	St. Charles
Keesal, Dennis	189	St. Charles
Kefalas, John C.	074	Washington
Keiper, Arthur S., III	026	Moberly
Keitges, Pierre W.	125	Overland Park, KS
Keithahn, Mari A.Z.	026	Columbia
Keller, Barbara P.	026	Columbia
Keller, Maurice J.	190	St. Louis
Keller, Robert M.	189	St. Charles
Keller, Stephen M.	190	St. Louis
Kellett, John G.	190	St. Louis
Kelley, Gilbert B.	010	Savannah
Kelly, Charles R.	125	Kansas City
Kelly, James B.	125	Kansas City
Kelly, John B.	102	Joplin
Kelly, John J.	190	St. Louis
Kelly, Joseph G.	050	N. Kansas City
Kelm, Shari L.	085	Ozark
Keltner, Raymond M., Jr.	190	St. Louis
Keltner, Raymond O.	125	Peculiar
Kemp, Michele E.	190	Chesterfield
Kempton, R. Scott	126	Kansas City
Kendall, Forrest H.	125	Kansas City
Kendis, Joseph B.	190	St. Louis
Kenneally, Cynthia Z.	190	St. Louis
Kennedy, David G.	190	St. Louis
Kennett, Jerry D.	026	Columbia
Kenney, Douglas R.	086	Clinton
Kenney, John D.	002	St. Louis
Kenney, John D., III	125	Kansas City
Kenney, Roy E.	166	Neosho
Kensel, Robert S.	082	Rogersville
Keohane, Mark	189	St. Charles
Kerkemeyer, George	150	Hannibal
Kerr, Harold H.	125	Shalimar, FL
Kessel, James W.	190	St. Louis
***Kesseler, Randall G.**	082	Springfield
***Kessler, Alan Z.**	125	Kansas City
Kessler, William D., Jr.	102	Joplin
Kester, Carla G.	082	Springfield
Kester, Nathan L.	082	Springfield
Key, James S.	082	Springfield
Khan, Abdul G.	190	Arnold
Khan, Khalid I.	042	Cape Girardeau
Khan, Khawla B.	002	St. Louis
Khanfar, Nasha't M.	202	Sikeston
Khatana, Anup K.	125	Prairie Village, KS
Khojasteh, Ali	026	Columbia
Khojasteh, Saaid	002	St. Charles
Khouri, Roger K.	190	Key Biscayne, FL
Khoury, Cecile S.	125	Leawood, KS
Khurana, Satish K.	125	Lenexa, KS
Kiburz, Douglas W.	178	Sedalia
Kichura, George M.	190	St. Louis
Kiehl, Mary M.	190	St. Louis
Kies, Richard L.	042	Cape Girardeau
Kiev, Jon	150	Hannibal
Kilbride, Howard W.	125	Kansas City
Kilgore, John W.	190	St. Louis
Killen, Duncan A.	125	Kansas City
Kim, Chul	034	Poplar Bluff
Kim, Stanley W.	190	St. Louis
Kim, Yang H.	074	Washington
Kim, Yong Kie	042	Cape Girardeau
Kimble, Harvey S.	125	Kansas City
Kimelman, Nathan	190	Atlanta, GA

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Kimlinger, William R.	Jefferson City	058
Kimmey, James R.	St. Louis	190
Kincaid, William L.	St. Louis	190
Kinder, James A.	Cape Girardeau	042
Kinder, Jerry L.	Cape Girardeau	042
Kindred, Lynn H.	Kansas City	125
King, Allison A.	Clayton	195
King, Dana M., III	St. Joseph	030
King, Donald K.	St. Louis	190
King, Eustace E., III	Chesterfield	190
King, Francis C.	St. Louis	190
King, Frank K.	Hayti	170
King, Gregory S.	St. Louis	190
King, J. Tenbrook	Prairie Village, KS	125
King, James A.	Des Peres	002
King, John V., Jr.	Ballwin	190
King, John V., Sr.	St. Louis	190
King, M. Kenton	St. Louis	190
King, Richard H.	Clinton	086
King, Tinna P.	St. Louis	190
Kingsbury, Robert J.	St. Peters	189
Kingsland, Robert C.	Sarasota, FL	190
Kinsella, Peter W.	St. Louis	190
Kinsella, Ralph A., Jr.	St. Louis	190
Kipfer, Robert E.	Springfield	082
Kipnis, David M.	St. Louis	190
***Kirila, Carol E.**	Kansas City	002
Kirkland, Jerry A.	Kansas City	050
Kirsch, Jeffrey P.	St. Louis	190
Kissane, John M.	St. Louis	190
Kissell, Richard W.	Springfield	082
Kister, George E.	Maryland Heights	189
Kistler, W. David, Jr.	St. Louis	190
Kitchens, Daniel L.	St. Louis	190
Kitchin, Winston H.	St. Louis	190
Kiyanclar, M. Emin	St. Louis	190
Klachko, David M.	Columbia	026
Klearman, Micki	St. Louis	190
Klein, Kendel L.	Mt. Vernon	166
Klein, Saul J.	St. Louis	190
Kleinschmidt, Donn C.	St. Louis	190
Klemm, J. Martin	Kansas City	125
Kleopfer, Lynn L.	Columbia	026
Kletzker, George R.	St. Louis	190
Kline, Carlyn M.	St. Joseph	030
Kline, Edmund W.	St. Joseph	030
Kline, James	St. Joseph	030
Klinkerfuss, George H.	Springfield	082
Klippel, Allen P.	St. Louis	190
Knabb, Henry F., Jr.	Springfield	082
Knabb, Kenneth E.	Springfield	082
Knakal, Roger C.	Kansas City	125
Knapp, Jane F.	Kansas City	125
Knight, James W.	St. Louis	190
Knight, William A., Jr.	St. Louis	190
Knipschild, Bedford F.	Marshall	198
Knoch, H. Kermit	Shawnee Mission, KS	125
Knock, Henry L.	St. Louis	190
Knop, Kevin F.	Liberty	002
Knopf, Harry L.	St. Louis	190
Knopf, Simon L.	Kansas City	126
Knowles, R. Raymond	St. Louis	190
Knowlton, Norman P., III	Springfield	082
Knudson, Dennis R.	Columbia	026
Kobbermann, Kobby J.	Springfield	082
Koch, F. Daniel	Kansas City	125
Kodner, Ira J.	St. Louis	190
Koehler, George A.	St. Louis	190
Koenig, Joel S.	St. Louis	190
Koenig, Marvin I.	St. Louis	190
Koerner, Kenneth A.	St. Louis	190
Kofkoff, Richard L.	Bridgeton	190
Koh, David W.	St. Louis	190
Kohler, Roy	Springfield	082
Kohm, Mary Jane F.	St. Louis	002
Koivunen, Debra G.	Columbia	026
Kokoska, Mimi S.	St. Louis	002
Kolb, Lisa G.	Jefferson City	058
Kolda, Michael A.	Cape Girardeau	042
Kolker, Allan E.	St. Louis	190
Koly, Mary E.	Florissant	195
Kolze, Vernon W.	Springfield	082
Koo, Michele D.	St. Louis	190
Koon, Ben H.	Bolivar	066
Koonce, John P.	Jefferson City	058
Koontz, Kenneth L.	Kansas City	125
Kopelson, Jeffrey C.	Brewester, NY	190
Kopp, Kenneth R.	Lenexa, KS	125
Kopp, Shelby K.	St. Louis	190
Koppers, Lawrence E.	Springfield	082
Korenblat, Phillip E.	St. Louis	190
Korenfeld, Michael S.	Washington	074
Korn, Dale E.	Columbia	027
Korn, Robert L.	St. Louis	190
Kory, Steven M.	Joplin	102
Kosse, Karl E.	St. Joseph	030
Kotner, Lawrence M., Jr.	St. Louis	190
Kouchoukos, Nicholas T.	St. Louis	190
Kouo, Louis	Cape Girardeau	042
Kowert, Edward H.	St. Louis	190
Kozminski, Mike	St. Joseph	030
Krabak, Michael J.	St. Louis	195
Kraeger, Russell R.	St. Louis	190
Kraemer, Bruce A.	St. Louis	190
Kraemer, Edwin T.	Lee's Summit	125
Kraft, Jacob	Palm Springs, CA	125
Krahn, Eve M.	Kansas City	050
Krahn, Michael J.	Kansas City	050
Krain, Samuel	St. Louis	190
Krajcovic, David P.	Chesterfield	190
Kramer, Robert S.	St. Louis	190
Kraner, Justin F.	St. Louis	190
Kranson, Seymour J.	Guilford, CT	125
Kratz, Donald P.	Springfield	082
Kraus, Frederick T.	St. Louis	190
Krautmann, John J.	Jefferson City	058
Krebs, Festus J., III	Kansas City	125
Krechel, Susan W.	Jonesburg	026
Kreski, Kenneth C.	House Springs	190
Kretchmar, Alan P.	St. Louis	190
Krettek, John E.	Chesterfield	190
Kreusser, Katherine L.	St. Louis	190
Krewet, Frank A., III	St. Louis	190
Kriegshauser, James W.	St. Louis	190
Kriegshauser, Lawrence A.	St. Louis	190
Krishna, Padma	Shawnee Mission, KS	125
Kroeger, George B., Jr.	St. Louis	190
Kroetz, Frank W.	Sikeston	202
Krojanker, David N.	St. Louis	190
Krojanker, Rolf J.	St. Louis	190
Kromer, Charles J.	St. Louis	190
Kronemer, Keith A.	Chicago, IL	190
Kronemer, Norton S.	St. Louis	190
Krug, Paul E.	Kansas City	125
Krummenacher, Thomas K.	St. Louis	190
Kruse, Carl R.	Palmyra	150
Kuangparichat, Manoch	Excelsior Springs	118
Kuckelman, Richard G.	Kansas City	125
Kuebel, Richard J.	St. Louis	190
Kuenzi, Donald E.	Kansas City	050
Kuganeswaran, Eliathamby	Kansas City	126
Kuhlman, Ralph F.	St. Louis	190
Kuhn, Lawrence F.	Bridgeton	190
Kulak, Gary	St. Louis	190
Kulick, Eric M.	Prairie Village, KS	125
Kulkarni, Nandini S.	St. Louis	190
Kumari, Vijaya	St. Louis	190
Kunda, Koteswara R.	St. Louis	190

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Kunin, Audrey G. Kansas City	**002**
Kunin, Jeffrey R. Kansas City	**125**
Kunst, Edward J. Ballwin	**190**
Kunz, Stephen R. Overland Park, KS	**125**
Kurtz, Karl J. Kansas City	**125**
Kussman, Mary E. St. Louis	**002**
Kuvshinoff, Boris W. Columbia	**026**
Kyger, John E. Independence	**125**

L

Laatsch, Robert H. Poplar Bluff	**034**
Labayen, Ricardo A. Overland Park, KS	**125**
Lacey, Hugh L. Joplin	**102**
LacKamp, Robert J. St. Joseph	**030**
Ladd, Charles B. St. Louis	**190**
Ladd, Christine M. St. Louis	**190**
Laiben, Gregg R. Kansas City	**125**
Laird, John M. St. Louis	**190**
Lakusiewicz, Ronald J. Poplar Bluff	**034**
Lally, James J. Kansas City	**125**
Lamb, Jerome P. Blue Springs	**125**
Lamb, Wanda St. Louis	**190**
Lambie, Rodger W. Kansas City	**125**
Lammoglia, Francisco J. St. Joseph	**030**
Lamonte-Jost, Daniel J. Columbia	**026**
Lampert, Benjamin A. Springfield	**082**
Lamping, J. Daniels St. Louis	**190**
Lampros, William P. St. Louis	**190**
Lampton, Lawrence M. Columbia	**026**
Landau, David W. St. Louis	**190**
Landau, William M. St. Louis	**190**
Landers, Burnell Independence	**125**
***Landers, Gary A.** N. Kansas City	**050**
Landgraf, James R. Independence	**125**
Landhuis, Leo R. Rochester, NY	**026**
Landis, George K. Raymore	**125**
Landrum, Alice L. Columbia	**026**
Landsbaum, Charles J. Jefferson City	**058**
Landwehr, Lawrence P. Warrensburg	**110**
Lane, Daniel K. St. Louis	**190**
Lang, John J. St. Louis	**190**
Lange, David R. Bridgeton	**190**
Langley, Harriet S. Kansas City	**125**
Lankford, Harold D. Mexico	**014**
Lapi, Angelo Boca Raton, FL	**125**
Laposky, Lynda L. Chesterfield	**190**
Larsen, William E. Shawnee Mission, KS	**125**
Larson, Kenneth W. Springfield	**082**
Laster, Jerry L. Joplin	**102**
Laster, Steven B. Kansas City	**125**
Latham, Raymond W. Mission Hills, KS	**125**
Latif, Azhar Lexington	**118**
Latimer, Walter N. Kansas City	**050**
Latour, Jonathan G. Columbia	**026**
Lattinville, Henry E. Bridgeton	**190**
Lauber, Joseph J. St. Louis	**190**
Lauer, Daniel J. Overland Park, KS	**125**
Lauer, John D. St. Louis	**190**
Laughlin, Edward J. Independence	**125**
Laughlin, Thomas P. Kansas City	**125**
Laux, France A. Tucson, AZ	**190**
Lavery, Daniel P. Westphalia	**058**
***Law, Byron D.** Kansas City	**050**
Lawhorn, Stephanie L. Shawnee Mission, KS	**125**
***Lawson, Gina E.** Smithville	**002**
Lawson, Noel W. Columbia	**026**
LaBach, James P. Overland Park, KS	**125**
LaDriere, Raymond J. St. Louis	**190**
LaFerriere, Keith A. Springfield	**082**
LaFoe, William K. Cape Girardeau	**042**
LaFrancis, Irving E. Joplin	**102**
LaHue, William C. Lexington	**118**
LaMonda, Gary W. Columbia	**026**
LaPietra, Martha M. Kansas City	**125**
***Leahy, Cindy** Holts Summit	**058**
Leary, Daniel J., Jr. St. Louis	**190**
Lederer, Charles M., Jr. Kansas City	**125**
Lederer, Charles M., Sr. Warrensburg	**110**
Lee, David Y. S. Cape Girardeau	**042**
Lee, Fransiska A. St. Louis	**190**
Lee, Gerald B. Kansas City	**214**
Lee, H. T. Columbia	**026**
Lee, Henry A. Snowmass Village, CO	**125**
Lee, Jung H. Crystal City	**106**
Lee, King Y. Shawnee Mission, KS	**125**
Lee, Leander K. St. Louis	**190**
Lee, Steven F. St. Louis	**002**
Lee, Susan L. Kansas City	**125**
Lee, Tae H. Leawood, KS	**125**
Lee, Thomas K. St. Louis	**190**
Lee, Wilfred Cape Girardeau	**042**
Leech, Maurice P. Fayette	**026**
Leeper, Sidlee W. Rocheport	**026**
Legarda, Maria M. Kansas City	**125**
Legler, Larry E. Independence	**125**
Lehman, John J., Jr. St. Louis	**195**
Lehman, Richard C. St. Louis	**190**
Lehman, Robert B. St. Louis	**190**
Leibsohn, Joel M. Independence	**125**
Leidenfrost, Ronald D. Chesterfield	**190**
Leifer, William W. Kansas City	**125**
Leightner, William F. St. Louis	**190**
Leitch, Steven M. Springfield	**082**
Leming, Bert H., Jr. St. Louis	**190**
Lenobel, Milton I. Longboat Key, FL	**190**
Lents, Rickey L. Cape Girardeau	**042**
Lentz, Harold C. Neosho	**166**
Lentz, Harold C., Jr. Independence	**125**
Lentz, Kathy J. Washington	**074**
***Lentz, Rodney D.** Jefferson City	**058**
Lenzenhuber, Karl J. Washington	**074**
Leonhardt, Erwin M. St. Louis	**190**
Lepinski, Sandra L. Kansas City	**125**
Lerner, Bruce Independence	**125**
Lerner, Scott A. Kansas City	**125**
Leroux, Gene H. Doniphan	**034**
Lerwick, Everett R. St. Louis	**190**
Leslie, James T. Jefferson City	**058**
Leslie, Thomas B. Mission, KS	**126**
Letizia, Wayne L. Independence	**125**
Levenson, Ernest Poplar Bluff	**034**
Levenson, Ina Poplar Bluff	**034**
Levi, Bernard Overland Park, KS	**125**
Levine, Laurence A. St. Charles	**190**
Levine, Richard S. St. Louis	**190**
Levitt, Joseph St. Louis	**190**
Levitt, Robert G. St. Louis	**190**
Levy, Beth K. St. Louis	**190**
Levy, Donald S. St. Charles	**189**
Levy, Edward S. St. Louis	**002**
Levy, Jerome F. St. Louis	**190**
Levy, Morton A. St. Louis	**190**
Lewandowski, Molly J. Leawood, KS	**125**
Lewin, W. Howard St. Louis	**190**
Lewis, J. Eugene, Jr. St. Louis	**190**
Lewis, Lawrence M. St. Louis	**190**
Lewis, Matthew T. Jefferson City	**058**
Lewis, Noel R. Springfield	**082**
Lewis, Revis C. Kansas City	**125**
Lewis, Robert D. St. Louis	**190**
Lewis, William S. Cape Girardeau	**042**
LeBlanc, Leo J. Clayton	**190**
LeFevre, Philip J. Springfield	**082**
Liang, Jing C. Independence	**125**
Libel, Roy D. Springfield	**082**
Lichtor, Joseph M. Mission Hills, KS	**125**
Lichty, Charles A. Shelbina	**150**
Lieb, Francis X. St. Louis	**190**
Lieb, Thomas F. St. Louis	**190**

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Lieberman, David M.	St. Louis	190
Lierz, Mark F.	St. Joseph	030
***Light, Diane L.**	Jefferson City	058
Lila, Aram	Excelsior Springs	050
***Lillig, James F.**	Kansas City	050
Lilly, Douglas R.	St. Louis	190
Lima, Jose A.	St. Louis	190
Limpiphiphatn, Dhajphong	Perryville	174
Limpiphiphatn, Ester P.	Perryville	174
Lin, Anthony C.	St. Louis	195
Lin, C. H.	Moberly	046
Lin, Chi-Hsi	Springfield	082
Lin, H. T.	Moberly	046
Lin, Hsiu-San	St. Louis	190
Linde, John W.	Rolla	135
Lindeman, John F.	Chesterfield	190
Link, Alexander J.	St. Louis	190
Linsenmeyer, Charles M.	St. Charles	189
Lintecum, Frederick B.	Kansas City	125
Lintecum, Neal D.	Kansas City	125
Linville, Howard E.	Leawood, KS	125
Lipschitz, Ervin	St. Louis	190
Lipsitz, Ellis S.	Chesterfield	190
Lisbon, Eleanor A.	Kansas City	125
Lischwe, Daniel H.	Bridgeton	190
Liss, Jay L.	St. Louis	190
Listerman, John C.	Lawrence, KS	030
Little, Blake A.	Joplin	102
Littlejohn, Robert T.	N. Kansas City	050
Litton, Lyle D.	Springfield	082
Litton, Lynn O.	Mt. Pleasant, SC	026
Litton, Nancy J.	Blue Springs	125
Litzow, Peter L.	St. Louis	190
Liu, Ben C.	Kansas City	125
Liu, Kenneth A.	St. Louis	195
Llorens, Alfred S.	Clemmons, NC	026
Loaiza, Sergio	Sikeston	202
Lobati, Frederick	Kansas City	126
Lockard, Orlyn O.	St. Joseph	030
Lockwood, Gary F.	Kansas City	125
Loeb, Mark	Columbia	026
Loeb, Richard H.	Springfield	082
Loeb, Virgil, Jr.	St. Louis	190
Loeffler, Roberta L.	Wichita, KS	190
Lofgreen, Craig S.	Kansas City	002
Loftus, Loretta S.	Kansas City	125
Logie, Macdonald B.	St. Louis	190
***Logston, David G.**	Springfield	082
Logue, John T.	Columbia	026
Lohmar, Roland E.	Columbia	026
Lohrentz, Lois H.	Westwood, KS	125
Loitman, Bernard S.	St. Louis	190
Lomax, John E.	Branson	208
Lombardo, Joseph A.	St. Louis	190
Lombardo, Richard J.	Belton	125
Londe, Alan M.	St. Louis	190
Londe, Sol	Northridge, CA	190
London, Stanley L.	St. Louis	190
Lonergan, James H.	Kansas City	125
Lonergan, Warren M.	Chesterfield	190
Long, Curtis W.	Butler	214
Long, Edwin T.	Kansas City	125
Long, John W.	Columbia	026
Long, Priscilla E.	Hannibal	150
Long, R. Stacy	Lake Lotawana	125
Long, Stephen E.	Springfield	082
Long, Timothy P.	Marthasville	074
Long, W. Steven	St. Joseph	030
Lonsway, Maurice J., Jr.	St. Louis	190
Loo, Kek-Khee	St. Louis	195
Loomis, James F.	St. Louis	190
Looney, Steven C.	St. Joseph	030
Lopez-Plata, Roberto	Leawood, KS	125
Lopez-Rocafort, Lissa M.	St. Louis	195
Lord, Richard E.	St. Louis	190
Lorei, John M.	Kansas City	002
Loren, Michael L.	Independence	125
Lorenc, Ernest	Springfield	082
Lorenzo, Edilberto B.	Poplar Bluff	125
Lottes, J. Otto	Lawrence, KS	190
Loughead, John R.	Poplar Bluff	034
Loutzenhiser, James K.	Kansas City	125
Love, Gerry A.	Liberty	125
***Lovern, Royce E.**	Washington	074
Lovinger, Warren C., Jr.	Nevada	214
Lovinggood, Thomas A.	Cape Girardeau	042
Lowe, H. Arch, Jr.	Springfield	082
Lowell, Jeffrey A.	St. Louis	190
Loyd, Earl L.	Holts Summit	058
Loynd, Robert C.	St. Louis	190
Lubniewski, Anthony J.	St. Louis	190
Lubowitz, Herbert	St. Louis	190
Luby, Maureen T.	St. Louis	195
Lucas, Thomas G.	St. Louis	190
***Lucio, John C.**	Jefferson City	058
Luckenbill, Paul T.	Park Rapids, MN	054
Luckett, Marc A.	Kansas City	126
Ludwig, Mark A.	St. Louis	190
Ludwikosky, Mike A.	Leawood, KS	125
Luechtefeld, Frank	Florissant	190
Lueckenhoff, Rebecca R.	Jefferson City	058
Luedke, Susan L.	St. Louis	190
Luerding, Jeffrey A.	Kansas City	050
Luetje, Charles M.	Kansas City	125
Luetkemeyer, Dennis C.	Columbia	027
Luetkemeyer, James G.	Jefferson City	058
Lugo, Samuel	St. Louis	190
Luh, Andrew M.	St. Louis	190
Lukavsky, James P.	Branson	208
***Lumsden, Todd J.**	Cape Girardeau	042
Lund, Herluf G.	St. Louis	190
Lund, Herluf G., Jr.	Chesterfield	190
Lundman, Hugh	Springfield	082
Lurie, H. H.	Springfield	082
Luther, George A.	St. Louis	190
Lutkewitte, Joseph F.	Ste. Genevieve	174
Lux, Gregory K.	Springfield	082
Luzecky, Michael H.	Springfield	082
Lyle, Robert R.	Versailles	120
Lyles, Rodney	Overland Park, KS	125
Lyman, Edward H.	St. Louis	190
Lynch, Thomas W.	Springfield	082
Lyon, David B.	Prairie Village, KS	125
Lyons, Daniel F.	Springfield	082
Lyskowski, John C.	Jefferson City	058
Lyskowski, Maria M.	Jefferson City	058
Lyss, Carl A.	St. Louis	190
Lytle, Edwin L.	St. Louis	190
Lytle, Michael F.	Shawnee Mission, KS	125

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Maben, Sam E.	Kansas City	125
MacDonald, Robert R., Jr.	St. Louis	190
MacDonald, Robert R., III	St. Louis	195
MacDonald, William C.	St. Louis	190
Macdonnell, Thomas M.	Marshfield	210
MacGee, Edwin E.	Kansas City	125
MacGorman, Linda R.	Springfield	082
Machek, Otakar	Snowmass Village, CO	190
Mack, Julie A.	St. Louis	190
Mack, Marvin L.	Columbia	026
Macleod, Angus	St. Louis	190
Macler, Henry H., Jr.	Hazelwood	190
MacKinnon, Susan E.	St. Louis	190
MacLaughlin, James C.	Hot Springs, AR	102
MacNaughton, Ralph E.	Shawnee Mission, KS	125
MacNaughton, Robert A	Louisburg, KS	125
MacNaughton, Robert A., II	Liberty	050
Madden, Michael L.	Kansas City	125

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Maddipati, Sreedevi	190	St. Louis
Madduri, Aruna D.	034	Poplar Bluff
Madduri, Sivaprasad D.	034	Poplar Bluff
Madrid, Dominador O.	190	St. Louis
Magaletta, George E.	002	St. Louis
Magalski, Anthony	125	Kansas City
Magaw, David C.	066	Everton
Magee, Robert L.	214	Eldorado Springs
Magee, W. Edwin	190	Imperial
***Magill, William S.**	082	Springfield
Magruder, Lyell M.	214	Nevada
Mahboubi, Aziz O.	202	Scottsdale, AZ
Mahmoud, Said F.	125	Kansas City
Mahnken, Robert F.	082	Springfield
Mais, Thomas E.	125	Shawnee Mission, KS
Maitz, Carlos A.	190	St. Ann
Major, Troy E.	082	Springfield
Majors, Patrick F.	190	St. Louis
Majzoub, Hish S.	102	Joplin
Makos, Mignon M.	030	St. Joseph
Malhotra, Vikas	135	Waynesville
Mallouk, Alexander G.	125	Kansas City
Mallow, James E.	125	Kansas City
Malmberg, Virgil L.	190	Chesterfield
Mangalat, Narayanan K.	102	Joplin
Mangum, William B.	125	Independence
Mani, Mary E.	190	St. Louis
Manire, John E.	102	Joplin
Mann, James K.	150	Hannibal
Mannis, Charles I.	190	St. Louis
Manske, Paul R.	190	St. Louis
Mantell, Jack M.	082	Springfield
Mantovani, John F.	190	St. Louis
Maple, Francis M.	082	Springfield
Marbarger, John P., Jr.	190	St. Louis
Marchiando, Albert W.	074	Washington
Marchosky, J. Alex	190	Chesterfield
Marcus, Michael D.	190	St. Louis
Marcus, Morris D.	190	St. Louis
Mardini, Edward E.	138	Bonne Terre
Margolis, David M.	190	St. Louis
Margolis, Robert P.	190	St. Louis
Marietta, William G.	042	Cape Girardeau
Markway, Gregory A.	125	Independence
Marr, Garrett L.	125	Kansas City
Marrs, David B.	189	St. Charles
Marsh, Jeffrey L.	190	St. Louis
Marshall, Hal E.	125	Overland Park, KS
Marshall, Jay P., II	190	Chesterfield
Marshall, Michael P.	002	Kansas City
Marshall, William G.	026	Glasgow
Marshall, William H.	058	Jefferson City
Marston, F. James	030	St. Joseph
Marti, Larry B.	135	Rolla
Martin, Chris J.	026	Columbia
Martin, Clarence A.	102	Joplin
Martin, Daniel J., Jr.	190	St. Louis
Martin, Daniel J., Sr.	190	St. Louis
Martin, David S.	190	Chesterfield
Martin, Jeffrey W.	190	St. Louis
Martin, Mark W.	125	Lee's Summit
Martin, Mary E.	195	St. Louis
Martin, Patricia A.	125	Kansas City
Martin, Richard A.	042	Cape Girardeau
Martin, Robert A.	206	West Plains
Martin, Scott A.	190	Chesterfield
Martin, Stanley B.	190	St. Charles
Marty, David R.	058	Jefferson City
Martz, John C.	190	St. Louis
Maska, Monte D.	082	Springfield
Maslan, Mark J.	125	Overland Park, KS
Mason, John E.	195	Clayton
Mason, Mary Jane	135	Steelville
Mass, Joan H.	190	St. Louis
Massey, Vickie	125	Kansas City
Masters, Edwin J.	042	Cape Girardeau
Masters, William H.	190	Tucson, AZ
Matava, Matthew	190	St. Louis
Mathew, Ruby	190	Chesterfield
Mathews, Jeffrey E.	190	St. Louis
Matile, Gerald U.	125	Kansas City
Matlock, Mark S.	102	Joplin
Matovich, Violet B.	125	Kansas City
Matson, Jeffrey A.	125	Kansas City
Matta, Camille S.	125	Kansas City
Mattax, James B., Jr.	082	Springfield
Matthews, J. Mark	125	Kansas City
Matthews, John G.	190	Fairway, KS
Matthews, John I.	058	Jefferson City
Matthews, Richard H.	135	Rolla
Matthews, Thomas D.	074	Washington
Maughs, Sydney B.	190	St. Louis
Mauldin, Charles C.	082	Springfield
Maupin, Kathy C.	190	Florissant
Maxson, Katherine A.	190	Chesterfield
Maxson, Theodore R.	110	Warrensburg
Mayer, John H., Jr.	125	Shawnee Mission, KS
Mayer, Robert A.	190	Pocono Pines, PA
Mayes, Ben R.	190	St. Louis
Maylack, Fallon H.	190	Florissant
Maynard, Colleen M.	125	Kansas City
Mayuga, Edgardo G.	190	St. Louis
Mayuga, Laureano G.	206	Cabool
Mayus, Joseph L.	082	Springfield
McAdam, C. Rush	190	St. Louis
McAfee, Gordon	082	Springfield
McAllister, John W., II	189	St. Peters
McArthur, Carole P.	126	Kansas City
McBride, Marsha M.	195	St. Louis
McCabe, Eugene J.	189	St. Charles
McCadden, Michael E.	190	St. Louis
McCalla, John P.	050	Kansas City
McCallister, Ben D.	125	Kansas City
McCallum, Kimberli E.	190	Chesterfield
McCanse, Andrew	125	Belton
McCanse, Lynn R.	050	N. Kansas City
McCarthy, Christopher E.	190	St. Louis
McClain, Thomas D.	082	Springfield
McClung, Mark W.	125	Kansas City
McConahay, David R.	125	Shawnee Mission, KS
McConchie, James E.	125	Lee's Summit
McCool, James F.	190	St. Louis
McCorcle, Marcus D.	082	Springfield
McCord, E. Scott	026	Columbia
McCormack, Robert E.	125	Kansas City
McCormick, James E.	050	Kansas City
McCown, Allan H.	190	St. Louis
McCoy, Frederick J.	125	Shawnee Mission, KS
McCray, Glen M.	082	Springfield
McCray, Stephen A.	050	N. Kansas City
McCroskey, Brian L.	125	Kansas City
McCroskey, Lon C.	125	Kansas City
McCullough, Joseph E.	125	Kansas City
McDavid, Robert E.	026	Columbia
McDermott, Alfred E.	174	Perryville
McDonald, James H.	125	Kansas City
McDonald, Margaret E.	102	Joplin
McDonald, Michael G.	102	Joplin
McDonald, Robert J.	058	Jefferson City
McDonald, Wallace	030	St. Joseph
McDonnell, John F.	125	Kansas City
McDonough, Michael	190	St. Louis
McDowell, James W.	014	Mexico
McElroy, George L., III	058	Jefferson City
McElroy, Glenn L.	026	Columbia
McEnroe, John D., Jr.	125	Kansas City
McFadden, Gene A.	118	Waverly
McFarland, H.R.	125	Shawnee Mission, KS

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McFarland, Rodney J.	**166**	Neosho
McGahee, C. Leon	**190**	St. Louis
McGinnis, William F.	**190**	Chesterfield
McGinty, Charles P.	**042**	Cape Girardeau
McGinty, Frank H.	**042**	Cape Girardeau
McGonigle, James P.	**102**	Longboat Key, FL
McGonigle, Michael M.	**102**	Joplin
McGovney, Janice K.	**050**	Kansas City
McGraw, James P.	**126**	Kansas City
McGregor, Patrick E.	**050**	N. Kansas City
McGuire, Patricia A.	**190**	St. Louis
McIntee, Rae A.	**125**	Kansas City
McIntire, Timothy L.	**058**	Jefferson City
McIntosh, Donald E.	**125**	Kansas City
McIntosh, Douglas A.	**042**	Cape Girardeau
McIntosh, Michele C.	**125**	Independence
McKay, Mark T.	**126**	Kansas City
McKeel, Thomas B.	**125**	Kansas City
McKenzie, Randolph A.	**125**	Kansas City
McKeown, Robert A.	**206**	Bucyrus
McKinley, Lois J.	**125**	Kansas City
McKinney, John W.	**190**	St. Louis
McKinsey, David S.	**125**	Kansas City
McKnight, Scott J.	**050**	Liberty
McLaren, David L.	**026**	Columbia
McLaughlin, Durnell	**125**	Kansas City
McLaughlin, Richard D.	**082**	Springfield
McLaughlin, Sean T.	**126**	Kansas City
McLemore, Willie O.	**125**	Kansas City
McMahon, Robert	**002**	St. Louis
McManus, Gerald	**050**	N. Kansas City
McMillan, David L.	**166**	Neosho
McMillen, James J.	**030**	St. Joseph
McMillin, John N.	**082**	Springfield
McMorrow, Brian C.	**195**	St. Louis
McMorrow, Nora K.	**190**	Crestwood
McMullin, Forbes A.	**190**	St. Louis
McMurry, Ted A.	**082**	Springfield
***McNabb, M. Jeffery**	**042**	Cape Girardeau
McNamara, Gerald R.	**125**	Kansas City
McNamara, John J.	**190**	St. Louis
McNay, Jennifer A.	**082**	Springfield
McNeal, Douglas M.	**082**	Springfield
McNitt, Jay D.	**125**	Kansas City
McPhee, Mark S.	**125**	Kansas City
McQuie, Ellen L.	**026**	Columbia
Meadows, C. Douglas	**190**	St. Louis
Mecker, Robert	**074**	Washington
Medler, John F.	**190**	St. Louis
Medler, P. Louis	**190**	St. Louis
Medlicott, William J.	**125**	Port Townsend, WA
Mehaffy, Orville A.	**102**	Joplin
Mehlhorn, Gary L.	**082**	Springfield
Mehr, David R.	**026**	Columbia
Mehra, Ravi	**190**	St. Louis
Meidl, Erik J.	**150**	Hannibal
Meier, Francis X.	**058**	Jefferson City
Meier, Mitchell S.	**102**	Joplin
Meiners, Theodore M.	**190**	Chesterfield
Mejia, Victor E.	**202**	Sikeston
***Melchior, David E.**	**174**	Perryville
Meldi, Dominic M.	**082**	Springfield
Melgaard, Sven R.	**125**	Hackensack, MN
Melia, B. J., Jr.	**125**	Kansas City
Mell, Roger L.	**190**	Chesterfield
***Mellies, Steven D.**	**042**	Cape Girardeau
Meltz, Gary J.	**189**	St. Charles
Memken, John A.	**150**	Hannibal
Memmolo, Ciriaco A.	**195**	St. Louis
Mendelsohn, George E.	**190**	Chesterfield
Mendelsohn, Robert S.	**190**	St. Louis
Mendez, Maria A.	**082**	Springfield
Mendonsa, Lawrence E.	**190**	Chesterfield
Menne, Marvin C.	**138**	Ironton
Mentgen, Carl N.	**082**	Springfield
Merenda, Frank J.	**190**	St. Louis
Merenda, James T.	**190**	St. Louis
Merenda, Sam J.	**190**	St. Louis
Meridy, Howard W.	**102**	Joplin
Merkel, Kurt D.	**190**	St. Louis
Merkle, John A.	**190**	St. Louis
Merritt, Burch A.	**190**	St. Louis
Merritt, Gregory A.	**125**	Kansas City
Merritt, Robert F.	**178**	Sedalia
Mertz, Janet S.	**125**	Kansas City
Mesa, Luis J.	**126**	Kansas City
Messmore-Arn, V. Paula	**126**	Kansas City
Mestad, Peter H.	**125**	Kansas City
Mestres, Hugh M.	**190**	St. Louis
Metry, Donald J., Jr.	**078**	Chillicothe
Metzler, Michael H.	**026**	Columbia
Meyer, D. Joseph, Jr.	**026**	Columbia
Meyer, Jay L.	**190**	St. Louis
Meyer, Jerry L.	**118**	Concordia
Meyer, John S.	**190**	Chesterfield
Meyer, John W.	**082**	Springfield
Meyer, Paul W.	**125**	Shawnee Mission, KS
Meyer, Randall E.	**058**	Jefferson City
Meyer, Robert C.	**190**	St. Louis
Meyers, Elsie F.	**190**	St. Louis
Meyers, Jerry R.	**189**	St. Peters
Meyers, John B.	**190**	St. Louis
Meyers, Robert W.	**190**	St. Louis
Meystrik, Rosellen S.	**082**	Springfield
***Michael, Roy A.**	**058**	Jefferson City
Michael, Vernon E.	**190**	St. Louis
Michaels, Robert H.	**082**	Springfield
Michelson, Richard B.	**125**	Kansas City
Middleton, Jerry N.	**190**	Chesterfield
Middleton, Mary Jo	**030**	St. Joseph
Miedema, Brent W.	**026**	Columbia
Mihalevich, John A., Jr.	**082**	Springfield
Milder, Barry D.	**190**	St. Louis
Milder, Benjamin	**190**	W. Palm Beach, FL
Miles, George O.	**125**	Shawnee Mission, KS
Miles, Richard W.	**102**	Joplin
Miles, Wayne B.	**082**	Springfield
Milgram, Byron A.	**125**	Kansas City
Mill, William B., Jr.	**190**	St. Louis
Miller, Charles, Jr.	**190**	St. Louis
Miller, Charles W.	**190**	St. Louis
Miller, Dace L.	**082**	Springfield
Miller, Donald	**058**	Jefferson City
Miller, Geoffrey W.	**190**	St. Louis
Miller, Gerald L., Jr.	**125**	Kansas City
Miller, Harry G.	**086**	Clinton
Miller, James E.	**190**	St. Louis
Miller, John T.	**125**	N. Kansas City
Miller, Joseph P.	**042**	Cape Girardeau
Miller, Jule P.	**190**	St. Louis
Miller, Kristin	**126**	Kansas City
Miller, Leroy J.	**026**	Columbia
Miller, Michael R.	**125**	Roeland Park, KS
Miller, Pamela S.	**135**	Rolla
Miller, Robert N.	**190**	St. Louis
Miller, Suzanne L.	**190**	Grover
Miller, Thomas A.	**002**	St. Louis
Miller, William D.	**030**	St. Joseph
Miller, Wilson H.	**125**	Shawnee Mission, KS
Millett, Ruth E.	**125**	Kansas City
Mills, Melissa J.	**002**	Overland Park, KS
Millwee, Elizabeth M.	**026**	Centralia
Milne, Jay L.	**082**	Springfield
Minkoff, I. Monica	**189**	St. Peters
Minnigerode, Lana K.	**125**	Kansas City
Minnigerode, Turner L.	**125**	Kansas City
Mir, A. Rauf	**125**	Kansas City
Mirbaha, Mitchell M.	**190**	St. Louis

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Mischnick, Carol R.	190	Chesterfield
Miskovsky, Emil F.	190	St. Louis
Missey, Wilburn C.	190	Chesterfield
Mistry, Tehmton S.	190	Columbia, IL
Mitchell, Andrew D.	125	Prairie Village, KS
Mitchell, Franklin L.	026	Columbia
Mitchell, Jason	027	Columbia
Mitchell, John D.	125	Kansas City
Mitchell, Lynn D.	026	Columbia
***Mitchell, Richard N.**	042	Cape Girardeau
***Mitchem, Randall E.**	058	Jefferson City
Mitra, Nirmal K.	125	Kansas City
Mitri, Osama	126	Kansas City
Mizell, Myron W.	082	Springfield
Moeller, F. Delbert	189	Lake St. Louis
Moffe, Thomas C.	082	Springfield
Mohs, Frank R.	190	St. Louis
Mohsen, Aly M.	082	Springfield
Molavi, Rameen J.	195	St. Louis
Molberg, Peter J.	082	Springfield
Molden, C. Scott	190	St. Louis
Molden, Charles A.	190	Ballwin
Mollman, H. Dennis	190	Chesterfield
Monaco, Michael	125	Harrisonville
Monafo, William W.	190	St. Louis
Monaghan, Greg G.	026	Columbia
***Monaghan-Berry, Nancy K.**	126	Parkville
Montani, David M.	195	St. Louis
Monteleone, Patricia L.	190	St. Louis
Montello, Samuel A.	125	Shawnee Mission, KS
Monterubio, Fred R., Jr.	190	St. Louis
Montes, Arturo C.	190	Florissant
Montgomery, Austin F.	190	St. Louis
Montgomery, Michael A.	125	N. Kansas City
Montie, Joseph E.	026	Columbia
Moody, Brent R.	195	St. Louis
Mooney-Smith, Patricia	125	Kansas City
Moore, Candice A.	214	Nevada
Moore, John M.	002	Kansas City
Moore, Michael R.	206	West Plains
Moore, Michael T.	214	Nevada
Moore, Richard E.	042	Cape Girardeau
Moore, Thomas B.	102	Joplin
Moran, Thomas M.	190	St. Louis
Morantz, Robert A.	125	Kansas City
Moranville, Benedict A.	030	St. Joseph
Morehead, William E.	070	Malden
Morehouse, Paul D.	074	Washington
Morello, Patrick J.	058	Jefferson City
Moreton, David W.	026	Columbia
Morey, Kirk P.	190	St. Louis
Morgan, David B.	125	Kansas City
Morgan, Dix R.	042	Cape Girardeau
Morgan, Edward B.	190	St. Louis
Morgan, Harry C.	190	Waynesville
Morgan, John L.	082	Springfield
Morgan, Mary	002	St. Louis
Morgan, Stephan S.	190	St. Louis
Morgan, Vincent I.	054	Cameron
Morgan, W. Tom, Jr.	026	Columbia
Morgan, Willy J. C.	190	E. St. Louis, IL
Moriconi, William J.	190	St. Louis
Moritz, Gerald	002	Bridgeton
Moritz, K. Lynne	190	St. Louis
Morley, Mary A.	190	Chesterfield
***Morley, Ronald F.**	058	Jefferson City
Morris, Alan H.	190	St. Louis
Morris, J. H.	125	Independence
Morris, John J.	026	Columbia
Morris, R. William	190	St. Louis
Morris, Terry V.	125	Independence
Morrison, R. Gideon	206	West Plains
Morrison, Richard A.	125	Independence
Morrison, Robert R.	050	Kansas City
Morrison, Stephen K.	082	Springfield
Morrison, Thomas A.	166	Aurora
Morrison, Tom V.	208	Branson
Morrow, N. Eugene	082	Springfield
Morton, David J.	190	St. Louis
Morton, Wayne L.	214	Osceola
Mosby, Larry D.	026	Columbia
Moseley, F. Thomas	082	Springfield
Moses, Robert A.	190	St. Louis
Mosher, Amy A.	190	St. Louis
Moss, Paul	125	Overland Park, KS
Mossie, Raymond D.	002	Kansas City
Motchan, Dennis G.	190	Bridgeton
Motier, Thomas H.	190	St. Louis
Motoc, Vlad T.	126	Kansas City
Mou, Susan M.	125	Kansas City
Mruk, Jozef S.	030	St. Joseph
Muchnick, Richard L.	190	St. Louis
Muckerman, Richard C., II	190	St. Louis
Muckerman, Richard I. C.	190	St. Louis
Muegge, F. David	082	Springfield
Mueller, Adolph R.	102	Joplin
Mueller, Clarence E.	190	O'Fallon
Mueller, Cynthia J.	002	St. Louis
Mueller, Joseph A.	190	St. Louis
Mueller, Martin J.	125	Kansas City
Mueller, Randall E.	026	Columbia
Muhammud, Faquir	190	St. Louis
Muhm, H. Yale	189	St. Charles
Mujica, Patricio H.	030	St. Joseph
Mukharji, Jhulan	125	Kansas City
Mulder, George D.	030	St. Joseph
Mullarky, Wilbur A.	190	Oviedo, FL
Mullen, Jack	138	Bonne Terre
Mullen, Mary E.	014	Mexico
Mullican, Charles N.	030	St. Joseph
Mullins, Bernard L.	050	Kansas City
Mullins, John E.	190	Chesterfield
Mundy, David C.	125	Kansas City
Mundy, William L.	125	Merriam, KS
Munger, Michael L.	125	Kansas City
Munoz, Phillip A.	125	Kansas City
Munro, John S.	125	Kansas City
Muraywid, Ahmad H.	014	Mexico
Murdock, Nathaniel	190	St. Louis
Murphey, Nathaniel G.	026	Ashland
Murphy, Daniel J.	190	Bridgeton
Murphy, J. Peter, Jr.	190	St. Louis
Murphy, James A.	030	St. Joseph
Murphy, John P.	125	Overland Park, KS
Murphy, Margaret A.	190	St. Louis
Murphy, Michael C.	190	St. Louis
Murphy, Timothy P.	030	St. Joseph
Murray, Timothy R.	126	Kansas City, KS
Murrell, H. Jerry	026	Columbia
Muscato, Joseph J.	026	Columbia
Muscato, Mary S.	026	Columbia
Musick, William D.	026	Jefferson City
Mutchnick, Norman	125	Kansas City
Myers, Carl M.	125	Platte City
Myers, Duane E.	102	Joplin
Myers, Gary H.	190	Chesterfield
Myers, George H.	125	Kansas City
Myers, John S.	125	Kansas City
Myron, Mark C.	125	Kansas City

N

Nachtigal, Michael P.	082	Springfield
Nadolski, Gary S.	030	St. Joseph
Nagle, Michael G.	102	Joplin
Nagy, Al L.	034	Doniphan
Nagy, Rickey E.	125	Kansas City
Nair, Jyotsna	026	Columbia
Nanson, Duane	026	Columbia
Narayan, Dilip L.	190	Chesterfield

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*Doctor of Osteopathy

Narkiewicz, Lawrence S.	190	St. Louis
Nash, Alison C.	190	St. Louis
Nash, Helen E.	190	St. Louis
Nash, Homer E., Jr.	190	St. Louis
Nashed, Rafat S.	190	St. Louis
Nathan, Lester J.	190	Fenton
Naunheim, Keith S.	190	St. Louis
Near, David M.	190	Florissant
Neblett, Lewis M.	082	Rogersville
Neely, J. Gail	190	St. Louis
Neighbor, Ernest H.	125	Kansas City
Neihart, Robert E.	125	Kansas City
Nelson, Bentley A.	125	Leawood, KS
Nelson, David E.	082	Springfield
Nelson, Donald C.	082	Springfield
Nelson, J. Roger	190	St. Louis
Nelson, Michael J.	125	Lee's Summit
Nelson, Richard E.	125	Kansas City
Nemec, Edward S.	190	St. Louis
Nepute, James A.	190	St. Louis
Nesselrode, John H.	125	Independence
Neu, Kenneth W.	082	Springfield
Neu, Leo T., Jr.	082	Springfield
Neu, Leo T., III	082	Springfield
*Neuenswander, Keith W.	050	Kansas City
Neuman, Neal	190	St. Louis
Newland, Craig C.	002	Liberty
Newman, Joseph A.	102	Joplin
Newman, Mary J.	166	Cassville
Newman, Matthew	190	St. Louis
Newman, Robert L.	125	Kansas City
Newman, William R.	102	Joplin
Newman-Koehn, Mica K.	198	Marshall
Newport, Gerald	190	Florissant
Ng, Edmond K.	195	St. Louis
Nguyen, Helen T.	030	St. Joseph
Nguyen, Khanh X.	002	Lenexa, KS
Nicholas, Stephen P.	190	St. Louis
Nicholis, G. Ronald	125	Kansas City
Nichols, Margaret E.	102	Joplin
Nichols, W. Kirt	026	Columbia
Nickell, Margaret B.	125	Kansas City
Nickell, Michael D.	102	Joplin
Nicolai, Charles H.	190	St. Louis
Niedermeyer, George J.	190	St. Louis
Nielsen, Carl H.	190	St. Louis
Niemeyer, John H.	190	St. Louis
Niesen, Anna R.	190	St. Louis
Niesen, Frank J.	190	St. Louis
Niesen, Thomas E.	190	Chesterfield
Nieuwenhuizen, Maarten	026	Columbia
Nigh, Stephen S.	125	Kansas City
Nigro, Thomas L.	125	Kansas City
Nile, David A.	190	St. Louis
Nishi, Toshio	190	St. Louis
Nitta, Diane M.	082	Springfield
Nix, J. Gustavo	066	Bolivar
Nixon, Edward E.	078	Independence
Noback, Richardson K.	125	Las Vegas, NV
Nogalski, Michael P.	190	St. Louis
Noh, Kyung M.	026	Columbia
Nolan, Charles J.	190	Chesterfield
Nolker, Stephen G.	126	Kansas City
Noltensmeyer, Milton H.	125	Lenexa, KS
Nomura, Roy M.	190	St. Louis
Nordhues, Craig A.	082	Springfield
Nordlicht, Scott M.	190	St. Louis
Norland, Charles C.	190	St. Louis
Norton, Jeffrey A.	190	St. Louis
Nottmeier, Eric W.	027	Columbia
Nouri, Hassan	190	St. Louis
Novack, Mark A.	190	Chesterfield
Nowotny, Thomas J.	190	St. Louis
Nuetzel, John A.	190	St. Louis
Nulton, Carnie C.	125	Kansas City
Nussbaum, Larry	050	Liberty
Nwaobasi, Sam	190	Florissant
Nyazee, Muhammad A.	190	Florissant
Nye, Robert A.	002	St. Louis
Nye, Terry R.	082	Springfield

O

Oakley, Margaret M.	190	St. Louis
Oberle, Paul A.	190	Ballwin
O'Brien, Edward J., Jr.	190	St. Louis
O'Brien, Robert M.	190	St. Louis
Occeno, Victor G.	166	Cassville
Ochoa, Pedro	190	Valmeyer, IL
Ockner, Samuel A.	190	Chesterfield
O'Connell, Timothy	190	St. Louis
O'Connor, John J.	074	St. Louis
O'Connor, Mary C.	125	Kansas City
O'Connor, Robert J.	190	Florissant
O'Donnell, Francis E.	190	St. Louis
O'Donnell, Susan M.	174	Ste. Genevieve
O'Farrell, Thomas P.	125	Shawnee Mission, KS
Ogle, William R. M.	042	Cape Girardeau
O'Hara, Patrick W.	126	Kansas City
O'Hearne, John J.	125	Kansas City
Ohlms, David L.	190	St. Louis
Ojascastro, Alejandro C.	190	St. Louis
Ojascastro, Lou	190	St. Louis
O'Keefe, James H., Jr.	125	Kansas City
Oleson, Gale B.	125	Blue Springs
Olive, G. Chapman	082	Springfield
Olive, George C.	166	Neosho
Olive, Paul M.	082	Springfield
Oliver, G. Charles	002	St. Louis
Oliver, George A.	138	Farmington
Oliver, Malcom B.	002	Republic
Olk, R. Joseph	002	Chesterfield
*Olomon, Angela S.	050	Gladstone
Olsen, Teresa A.	082	Springfield
Olson, E. Rule	082	Springfield
Olson, Gary S.	042	Cape Girardeau
Olson, James H.	050	Liberty
Olson, Richard O.	189	St. Charles
Olson, Robert J.	082	Joplin
O'Malley, James F.	125	Leawood, KS
Omell, Gary H.	190	St. Louis
Onder, Robert F.	190	St. Louis
O'Neal, Lawrence W.	190	St. Louis
O'Neil, Jerome H., Jr.	190	St. Louis
Ong, Eng L.	190	St. Louis
Ong, Ofelia S.	190	St. Louis
Onken, Henry D.	190	St. Louis
Oppenheimer, Henry E.	190	St. Louis
Opper, Susan E.	125	Kansas City
Oppermann, Karen J.	125	Independence
Orgel, S. Michael	190	St. Louis
Orlando, Louis A.	125	Kansas City, KS
Oro, John J.	026	Columbia
O'Rourke, James E.	174	Ste. Genevieve
Orr, Robert M.	125	Kansas City
Orsay, Paul K.	190	Chesterfield
Ortbals, David W.	190	Chesterfield
Orth, O. Gerald	026	Columbia
Ortiguero, Leopoldo M.	190	St. Louis
Ortmeyer, Leroy F.	190	St. Louis
Osbourn, Richard A.	038	Fulton
Ossman, Julian A.	058	Jefferson City
Ost, Mark D.	125	Kansas City
Ostapowicz, Frank	190	St. Louis
Ostapowicz, Tamara L.	190	St. Louis
Ostergaard, Daniel J.	125	Kansas City
O'Sullivan, Daniel F.	190	St. Louis
Oswood, Mark C.	195	Maryland Heights
Ota, David M.	026	Columbia
Othmer, Ekkehard	050	Kansas City

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*Doctor of Osteopathy

Otis, Stephanie A.	002	St. Louis
O'Toole, Lisa	125	Overland Park, KS
O'Toole, Patrick M.	125	Kansas City
Ott, F. Thomas	190	St. Louis
Ott, Harold J., II	190	St. Louis
Ott, William J.	190	St. Louis
Otto, Steven M.	082	Springfield
Otto, William J.	082	Springfield
Ottolini, James L.	190	Chesterfield
Ouellette, David F.	150	Hannibal
Ovens, Lisa	082	Springfield
Overend, Don S.	082	Springfield
Overesch, Harry B.	125	Kansas City
Owen, Robert F.	190	St. Louis
Owens, Robert H.	125	Shawnee Mission, KS
Owens, William D.	190	St. Louis
Ozar, Milton B.	125	Miami, FL
Ozenberger, Larry A.	054	Plattsburg

P

Pacheco, Jose M.	082	Springfield
Packman, Paul	190	St. Louis
Packman, Robert C.	190	St. Louis
Padilla, Teresita C.	190	Chesterfield
Padula, Richard T.	125	Shawnee Mission, KS
Paez, Mauro A.	190	St. Louis
Paff, David G.	082	Springfield
Page, Jennifer L.	190	St. Louis
***Page, Jordan C.**	027	Jefferson City
***Page, Lawrence V.**	102	Joplin
Page, Sam L., Jr.	195	St. Louis
Painter, Andrew E.	202	Portageville
Painter, Lattie B.	170	Portageville
Palazola, Joseph M.	125	Kansas City
Palcheff, Chris L.	082	Springfield
Palen, James E.	042	Cape Girardeau
Palenske, Robert L.	070	Homersville
Paletta, Francis X., Jr.	190	St. Louis
Paletta, Francis X., Sr.	190	St. Louis
Paletta, Frank	190	St. Louis
Paletta, Victor L.	190	Bridgeton
***Palmer, Allen S.**	190	Bridgeton
Palmer, Stephen M.	190	St. Louis
Pancoast, Charles H.	042	Cape Girardeau
Paone, Douglas B.	125	Kansas City
Papreck, K. T.	198	Marshall
Paradelo, Jorge C.	125	Kansas City
Paraiso, Marie F.	125	Kansas City
Parelman, Allen G.	125	Kansas City
Parikh, Sharad P.	190	Florissant
Paris, William H.	190	Bridgeton
Park, Bert E.	082	Springfield
Park, Duk J.	106	Festus
Park, Kee B.	042	Cape Girardeau
Park, Thomas	027	Columbia
Park, William I., Jr.	082	Springfield
Parker, Arthur C.	034	Destin, FL
Parker, Brent M.	026	Colorado Springs, CO
Parker, Craig A.	125	Kansas City
Parker, Kim E.	125	Kansas City
Parker, Thomas W.	190	St. Louis
Parkins, George K.	125	Kansas City
Parks, Charles	190	St. Louis
Parks, David A.	195	St. Louis
Parks, Deborah L.	190	St. Louis
Parks, Jon C.	034	Poplar Bluff
Parks, Joseph J.	026	Jefferson City
Parks, Lyle F.	082	Springfield
Parks, William C.	026	Columbia
Parres, Jeffrey A.	190	Chesterfield
Parsons, Clyde W., III	082	Springfield
Partamian, Krikor O.	030	St. Joseph
Parulekar, Dilip G.	038	Fulton
Parwatikar, Sadashiv D.	190	St. Louis
Paskar, Larry D.	190	Chesterfield
***Pasowicz, Timothy C.**	126	Shawnee Mission, KS
Passanante, Bartholomew M.	190	St. Louis
Patel, Ashokkumar B.	190	St. Louis
Patel, Bipin T.	030	St. Joseph
Patel, Dilip H.	190	St. Louis
Patel, Indu B.	106	Barnhart
Patel, Raman J.	030	St. Joseph
Patel, Yogesh P.	190	Fenton
Patrick, Roman L.	190	St. Louis
Patrick, Scott E.	126	Prairie Village, KS
Patterson, Alec	002	St. Louis
Patterson, Donald C.	026	Columbia
Patterson, Donald R.	102	Joplin
Patterson, Grover S.	102	Carthage
Patty, Carl F.	034	Poplar Bluff
***Patty, John R.**	034	Poplar Bluff
Paulson, Gordon S.	030	St. Joseph
Pavelonis, Joel D.	002	Kansas City
Pavlovich, Andrew S.	125	Independence
Pavlu, Robert R.	118	Waverly
Pawsat, John E.	125	Kansas City
Payne, David E.	026	Columbia
Payne, Meredith C.	190	Chesterfield
Pearce, Eugene W. J.	125	Kansas City
Pearman, Carl C.	002	Kansas City
Pearse, Carlton S.	190	Chesterfield
Pearson, Richard L.	174	Ste. Genevieve
Pearson, Thomas C.	082	Springfield
Pearson, William E.	190	St. Louis
Peck, William A.	190	St. Louis
Peden, Virginia H.	190	Maryland Heights
***Peer, Peter M.**	126	Kansas City
Pehlman, Joseph E.	070	Malden
Peick, Ann C.	034	Poplar Bluff
Peimann, Nathan P.	195	St. Louis
Pelican, George	190	St. Louis
Pendell, Paul W.	125	Raymore
Penilla, Antonio R.	190	St. Louis
Pennell, Richard C.	190	St. Louis
Penninger, William H.	082	Springfield
Pennington, Michael S.	166	Springfield
Pennoyer, James	190	St. Louis
Pentella, Karen J.	190	St. Louis
Peplinski, Gary R.	195	St. Louis
Pepose, Jay S.	002	St. Louis
Pepper, Edward G.	190	St. Louis
Pereira, Mary Beth	190	St. Louis
Perez, Adamor R.	190	St. Louis
Perez, Blanca M.	190	St. Louis
Perez, Carlos A.	190	St. Louis
Perez, Robert J.	190	St. Louis
Perinetti, Enrique P.	190	St. Louis
Perkins, David E.	190	Chesterfield
Perll, Maurice F., Jr.	125	Kansas City
Perll, Michael F.	125	Kansas City
Perll, Peter D.	014	Mexico
Perlmutter, John C.	189	St. Charles
Perna, Vincent P.	189	St. Louis
Pernoud, Flavius G., Jr.	190	St. Louis
Pernoud, Flavius G., III	190	St. Louis
Pernoud, Joan M.	190	St. Louis
***Perry, Christopher M.**	002	St. Louis
Perry, Michael C.	026	Columbia
Perryman, Douglas R.	125	Kansas City
Perryman, J. Chris	125	Kansas City
Perryman, Kathy M.	125	Kansas City
Petelin, Joseph B.	125	Shawnee Mission, KS
Peters, Walter R.	026	Columbia
Petersen, James H.	002	Chesterfield
Petersen, Larry D.	082	Springfield
Peterson, Carl M.	125	Kansas City
Peterson, Charles R.	120	Osage Beach
Peterson, Craig A.	082	Springfield
Peterson, Frederick D.	190	St. Louis

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*Doctor of Osteopathy

Peterson, Ila M.	125	Overland Park, KS
Peterson, Jay T.	125	Kansas City
Peterson, Jeffrey J.	126	Independence
Peterson, Stanley S.	082	Springfield
Peterson, Stephen E.	125	Kansas City
Peterson, Walter R.	125	Kansas City
Petit, Carl A.	120	Osage Beach
Petkovich, Frank O.	190	St. Louis
Pettett, Gary	125	Kansas City
Pew, Becky A.	190	St. Louis
***Pewitt, Charles S.**	042	Jackson
***Pfautsch, Mark L.**	042	Cape Girardeau
Pfefer, Leland U.	026	Columbia
Pfefferkorn, David A.	202	Sikeston
Phelan, Christie B.	125	Shawnee Mission, KS
Phelan, David	125	Overland Park, KS
Philgreen, Donald E.	125	Kansas City
Philipneri, Marie D.	126	Kansas City
Phillips, Abraham M.	190	St. Louis
Phillips, Daniel	190	St. Louis
Phillips, Granville J.	110	Warrensburg
Phillips, John J.	190	Florissant
Phillips, Kenneth D.	042	Cape Girardeau
Phillips, Robert L.	027	Columbia
Phillips, Ronald L.	148	Kirksville
Phillips, Thomas P.	125	Kansas City
Phillips, William J.	190	Chesterfield
Philpott, Gordon W.	190	St. Louis
Piccirillo, Jay F.	190	St. Louis
Pickard, Clarence M.	026	Columbia
Pickens, Andrew T.	190	St. Louis
Picker, Selwyn	190	St. Louis
Pickering, Lee I.	125	Independence
Picus, Joel	002	St. Louis
Piebenga, Larry W.	125	Kansas City
Piehler, Jeffrey M.	125	Kansas City
Piening, Kurt A.	189	St. Charles
Pierce, Dan L.	026	Columbia
Pignotti, Blase J.	190	St. Louis
Piker, K. Dewayne	082	Springfield
Pimentel, Esperanza M.	190	St. Louis
Pinckley, James N.	082	Springfield
Pineda, Hector O.	190	St. Louis
Pineda, Juan J.	026	Columbia
Pingelton, William B.	026	Columbia
Pingleton, William W.	050	Shawnee Mission, KS
Pinkham, Chris M.	050	Kansas City
Pintado, Susan O.	102	Joplin
Piontek, James F.	050	Liberty
Piontek, Jerome G.	190	Chesterfield
Piper, Terrence L.	189	St. Charles
Pitiyanuvath, Tasanaporn	125	Kansas City
Pitney, Phillip W.	150	Louisiana
Pitsinger, N. Bruce	190	Chesterfield
***Pitt, James B.**	120	Osage Beach
Pittman, David L.	026	Columbia
Pittman, Gerald R.	190	St. Louis
Pittmann, Thomas	190	St. Louis
Pjura, George A.	042	Cape Girardeau
Plax, Steven I.	190	St. Louis
Plowman, Edward M.	150	Hannibal
Podolsky, Howard S.	002	St. Louis
Podrecca, Guido I.	082	Key Largo, FL
***Poepsel, Philip R.**	190	Bridgeton
Poger, Marshall E.	190	St. Louis
Poggemeier, David A.	189	St. Charles
Poggemeier, William H.	189	St. Charles
Pogson, George W., III	125	Independence
Pohl, David L.	190	St. Louis
Pohlman, Thomas M.	190	Chesterfield
Pojanasomboon, Pichat	135	Rolla
Politi, Gregory B.	125	Kansas City
Politte, Lenard L.	026	Columbia
Pomeranz, Howard D.	195	Boston, MA
Pomphrey, Martin M., Jr.	190	Chesterfield
Pon, Marcelino	190	St. Louis
Ponstingl, Raana J.	190	St. Louis
Pontillas, Job B.	174	Perryville
Poole, Anthony G.	202	Sikeston
Porte, Karen L.	102	Joplin
Porter, Charles B.	125	Kansas City
Porter, Michael J.	125	Kansas City
Porter, Susan S.	125	Kansas City
Portnoff, Lee S.	190	St. Louis
Porvaznik, John T.	190	Chesterfield
Posey, Douglas H., Jr.	030	St. Joseph
Post, Stephen L.	190	St. Louis
Postma, George S., Jr.	125	Mission, KS
Potashnick, Robert	190	St. Louis
Pottenger, L. Kenneth	102	Joplin
Potter, Caryl A., Jr.	030	St. Joseph
Potts, Dan E.	190	Chesterfield
Potts, Donald A.	125	Kansas City
Potts, Fred E., III	082	Laredo, TX
Potts, Gregory A.	074	Washington
Poulose, Abraham K.	125	Prairie Village, KS
***Pourakbar, Mohammad K.**	126	Kansas City
Powell, Alan E.	125	Independence
Powell, Edwin M.	082	Springfield
Powell, John A.	190	St. Louis
Powell, Kenneth R.	082	Springfield
Powell, Lisa G.	082	Springfield
Prasad, Chandra N.	058	Jefferson City
Prater, Bill G.	082	Springfield
Prater, Kimberley A.	082	Springfield
Prater, Thomas G.	082	Springfield
Prelutsky, David J.	190	St. Louis
Prensky, Arthur L.	190	St. Louis
Presley, Jimmy C.	082	Springfield
Preston, Bruce E.	206	West Plains
Previti, Vincent	082	Springfield
Prey, Marianne U.	190	St. Louis
Pribor, Elizabeth F.	190	St. Louis
Prica, George, Jr.	026	Columbia
Price, Carl I.	082	Springfield
Price, Hilton I.	190	St. Louis
Price, Nigel J.	125	Kansas City
Price, Patrick K.	125	Shawnee Mission, KS
Price, Richard B.	125	Overland Park, KS
Price, Richard C.	214	Harrisonville
Prickett, David C., Jr.	050	Kearney
Prince, Yvonne M.	135	Salem
Pringle, Scot G.	042	Cape Girardeau
Pro, John D.	125	Kansas City
Proctor, Donald C.	178	Sedalia
Proskey, Vincent J.	190	Chesterfield
Prost, Monika M.	026	Columbia
Prstojevich, Steven J.	125	Kansas City
Pruett, Burchard S.	190	Prescott, AZ
Pruett, Don S.	190	St. Louis
Pruett, Paul L.	082	Springfield
Pruitt, David	102	Joplin
Pryor, Carolyn J.	190	Florissant
Pryor, Harold J.	125	Kansas City
Pryor, Ira Joe	102	Joplin
Psaltis, Philip E.	030	St. Joseph
Puckett, Charles L.	026	Columbia
Puckett, Lynn M.	026	Columbia
Pugh, Richard G.	125	Blue Springs
Purcell, Henry E.	190	St. Louis
Purcell, John J., Jr.	190	St. Louis
Purcell, Paul W.	050	Renton, WA
Purcell, Richard D.	082	Springfield
Puro, Edward A.	190	Florissant
Putnam, John L.	082	Springfield
Pyeatte, Jacob P., Jr.	042	Cape Girardeau
Pyszczynski, Dennis R.	125	Kansas City

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Q

Quer, Erich A.	125	La Quinta, CA
Quiason, Arturo G.	125	Independence
Quiason, Emmeline P.	125	Independence
Quick, William W.	125	Kansas City
Quinn, Paul S.	082	Strafford
Quinn, Rodney D.	082	Springfield
Qureshi, Abdul R.	190	St. Louis

R

Rabang, Lazaro U.	078	Bethany
Raborar, Arteso C.	082	Springfield
Racela, Luz S.	125	Leawood, KS
Rader, Ada E.	125	Kansas City
Rader, Edward S.	190	St. Louis
Radford, Diane M.	190	St. Louis
*Radinsky, Stephen	190	St. Louis
Radley, Anne M.	190	Florissant
Ragland, John E.	058	Bonnots Mill
Rahman, Moudur	190	Chesterfield
Rajcher, Wilma J.	026	Columbia
Raju, Niranjana	174	Ste. Genevieve
Rall, Kenneth L.	026	Independence
Ramey, Ehret O.	125	Kansas City
Ramirez, Ricardo M.	034	Kansas City
Ramirez, Samuel G.	190	St. Louis
Ramos, Americo G.	125	Shawnee Mission, KS
Ramos, Ricardo R.	190	St. Louis
Ramsey, J. Darryl	042	Cape Girardeau
*Ramsey, Jesse R.	042	Cape Girardeau
Ramsey, Robert H.	190	Bridgeton
Randolph, Bernard C.	190	St. Louis
Randolph, Bernard C., Jr.	002	Bridgeton
Randolph, Gary	102	Joplin
Randolph, Kerry A.	082	Springfield
Ranginani, Anil K.	010	Savannah
Rangineni, Rajagopal	030	St. Joseph
Rankin, Diane	190	St. Louis
*Rankin, W. Dale	102	Joplin
Rao, Ricardo	190	Chesterfield
Rao, Sumati	190	St. Louis
Rao, Vijaya Kumar P.	102	Joplin
Rapp, Earl L.	150	Hannibal
Rappold, Henry O.	002	Chesterfield
Ratcliff, Keith M.	074	Washington
Ratkin, Gary A.	190	St. Louis
Ratnam, Dasari V.	125	Kansas City
Rau, Michael E.	074	Washington
Rauba, Alan T.	058	Jefferson City
Rawlins, Fred E.	042	Cape Girardeau
Rawson, Perry G.	074	Washington
*Ray, Terry L.	026	Columbia
Raybould, Michael W.	125	Kansas City
Raynor, Richard C.	198	Marshall
Razzaq, A.	190	St. Louis
Reaney, John A.	125	Kansas City
Rearden, Timothy P.	190	St. Louis
Reardon, James P.	050	N. Kansas City
Reardon, Thomas F.	190	St. Louis
Reardon, Thomas M.	050	N. Kansas City
Rector, Joe L.	125	Shawnee Mission, KS
Reddy, Abbiah N.	034	Poplar Bluff
Reddy, Agara S.	026	Columbia
Reddy, Anchala N.	206	West Plains
Reddy, Nalini A.	206	West Plains
Redfern, David L.	082	Springfield
Redington, James C.	050	N. Kansas City
Redington, James C., Jr.	190	St. Louis
Redmon, Conchita M.	082	Springfield
Rednam, Krishnarao V.	190	St. Louis
Reed, Glen H.	214	Appleton City
Reed, Jonathan R.	190	St. Louis
Reed, Timothy F.	178	Sedalia
Reeder, Charles C.	050	Smithville
Reeder, Stephen M.	082	Springfield
Reese, Jon A.	082	Springfield
Reese, Lester T.	190	St. Louis
Reeves, R. Bradley	102	Joplin
Reeves, Col., Glen I.	190	N. Bethesda, MD
Regas, Stephen L.	126	Kansas City
Reh, Edward P., Jr.	190	St. Louis
Reh, Thomas E.	190	St. Louis
Reichert, Timothy J.	190	St. Louis
*Reinbold, Thomas R.	206	Houston
Reinhard, Edward H.	190	St. Louis
Reinhardt, J. Robert	125	Kansas City
Reinsvold, Thomas M.	102	Joplin
Reintjes, Stephen L.	125	Kansas City
Reisler, David M.	190	Chesterfield
Reiss, Jeanne E.	125	Kansas City
Reister, Philip D.	125	Kansas City
Rejent, Anthony J.	190	St. Louis
Rendleman, George F., Jr.	190	St. Louis
Rengachary, Dhanalakshmi	125	Kansas City
Renner, Gregory J.	026	Columbia
Renner, Julie A.	190	St. Louis
*Reno, Lisa K.	018	Lamar
Retter, Kenneth W.	042	Cape Girardeau
Reust, Carin E.	082	Springfield
Revare, Paul	050	Kansas City
Revels, Harry R., III	125	Leawood, KS
Reyes, Jose T.	190	St. Louis
Reyes, Lirio M.	082	Springfield
Reyes, Luis A.	190	Arnold
Reynolds, James A.	190	Chesterfield
Reynolds, Robert B., Sr.	190	Carbondale, CO
Reynolds, Susan K.	190	St. Louis
Reynolds, William R.	082	Springfield
Rezvani, Laghaieh	202	Sikeston
Rhee, Seoung E.	190	St. Louis
Rhoades, Charles E.	125	Kansas City
*Rhoads, Mark D.	102	Joplin
Rhodes-Stark, Kelly L.	125	Kansas City
Riaz, M. Afzal	174	Ste. Genevieve
Ribaudo, J. Michael	190	St. Louis
Ricci, Walter J.	125	Overland Park, KS
Ricci, Walter F.	125	Shawnee Mission, KS
Rice, Karen H.	058	Jefferson City
Rice, Kathleen G.	082	Springfield
Rice, Lee Roy	102	Joplin
Rice, Valerie M.	050	Kansas City, KS
Rich, Keith M.	190	St. Louis
Rich, Margaret M.	190	St. Louis
Richards, Dean D., III	125	Overland Park, KS
Richards, Pamela	195	St. Louis
Richardson, Curtis J.	030	St. Joseph
Richardson, Donna T.	074	Union
Richardson, George A.	074	Union
Richardson, Marion W.	125	Kansas City
Richardson, Norbert L.	074	Union
Richardson, Thomas F.	190	St. Louis
Richardson, William R.	074	Union
Richert, Robert C.	125	Kansas City
Richmond, Ron	042	Cape Girardeau
Ridenhour, C.E. Gene	026	Columbia
Ridenour, Brock D.	190	St. Louis
Ridgeway, William G.	190	St. Louis
Ridings, Harold D.	042	Cape Girardeau
Riechers, Thomas B.	074	Washington
Rieger, Frank G.	026	Columbia
Ries, Douglas A.	190	Chesterfield
Rigden, L. Brick	125	N. Kansas City
Rikli, Arthur E.	026	Columbia
Riley, Charles T.	118	Richmond
Riley, Joel Y.	002	St. Louis
Rinck, Edward C.	214	Nevada
Rinehart, Gregory C.	190	St. Louis
Riner, Ronald N.	190	St. Louis
Ring, Daniel S.	195	St. Louis

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Ring, Lisa B.	Bridgeton	190
Ringer, C. Nelson	Cape Girardeau	042
Riojas, Lisa A.	Rolla	135
Rippe, William F.	St. Joseph	030
***Ripperger, Kevin L.**	Springfield	082
Riscoe, James M.	Joplin	102
Rising, Dean R.	Springfield	082
Rispler, David T.	Jefferson City	058
Ritter, C. J.	Cape Girardeau	042
Ritter, Carl F.	Sedona, AZ	042
Ritter, Hubert A.	Chesterfield	190
Ritter, John L.	Springfield	082
Ritter, R. August, 111	Cape Girardeau	042
Ritter, Ray A., Jr.	Cape Girardeau	042
Ritter, Raymond A., Sr.	Cape Girardeau	042
Rizzo, Adolfo E.	St. Charles	190
Roach, Mona S.I.	Prairie Village, KS	125
Robbins, Philip L.	St. Louis	190
Robbins, Thomas D.	Jefferson City	058
Roberts, Charles C.	Kansas City	125
Roberts, Christopher H.	Joplin	102
Roberts, Grosvenor G.	Kansas City	125
Roberts, Harold K.	Clayton	190
Roberts, Howard H.	Joplin	102
Roberts, Jonathan M.	Jefferson City	058
Roberts, Perry T.	Oxford, MS	042
Roberts, Phyllis G.	St. Joseph	030
***Roberts, Rebecca L.**	Kansas City	030
Roberts, Theodore W.	Sikeston	202
Robertson, Frank G.	Cuba	190
Robertson, Terence A.	Leawood, KS	125
Robertson, William D.	Poplar Bluff	034
Robinett, Wade V.	Kansas City	125
Robinow, Jay S.	Kansas City	125
Robinson, Arthur W.	Shawnee Mission, KS	125
Robinson, Gary L.	Springfield	082
Robinson, Gordon H.	St. Louis	190
Robinson, James C.	Columbia	026
Robinson, Jay G.	Kansas City	125
Robinson, Nicholas F.	Kennett	070
Robinson, Ronald L.	Cape Girardeau	042
Robinson, Van M.	Carefree, AZ	198
Robinson, William J.	Overland Park, KS	125
Robison, Paul D.	Joplin	102
Rodefeld, Mark D.	St. Louis	195
Rodgers, Dorothy L.	Columbia	026
Rodgers, George H.	Leawood, KS	125
Rodgers, Jody A.	Jefferson City	058
Rodgers, Samuel U.	Kansas City	125
Rodgers, W. Blake	Jefferson City	058
Rodrigo, Bernardo R.	St. Louis	190
Rodriguez, Gregorio L.	Charleston	202
Rodriguez, Luis C.	St. Louis	195
Rodriguez, Ubaldo R.	St. Louis	190
Roehrs, David H.	Sedalia	178
Roehrs, Marvin E.	Marshall	198
Rogers, Casey	Mexico	014
Rogers, David B.	Springfield	082
Rogers, H. Bryan	St. Louis	190
Rogers, James D.	Springfield	082
Rogers, James T.	Springfield	082
Rogers, John T.	St. Joseph	030
Rogers, Joseph D.	Springfield	082
Rogers, Robert L.	Kansas City	125
Rogler-Brown, Ginene M.	Overland Park, KS	126
Roh, Joseph J.	Kansas City	125
Roh, Lynn H.	Kansas City	125
Roller, James A.	Columbia	026
Rollo, John L.	St. Louis	190
Romaker, Ann M.	Kansas City	125
Romkema, George E.	St. Louis	190
Rondinelli, Robert D.	Kansas City	125
Roper, Charles L.	St. Louis	190
Rose, Barry A.	Overland Park, KS	125
Rosecan, Marvin	Belleville, IL	190
Roselman, Michael J.	Springfield	082
Rosen, Howard M.	N. Kansas City	125
Rosen, Larry A.	Independence	125
Rosen, William K.	Springfield	082
Rosenbaum, Herbert E.	St. Louis	190
Rosenbaum, Jessica	St. Louis	195
Rosenberg, David S.	Florissant	190
Rosenbloom, Michael	Hollywood, FL	190
Rosenthal, Debra D.	St. Louis	190
Rosenthal, Howard G.	Kansas City	125
Rosenthal, Randall	St. Louis	190
Rosenthal, William N.	Kansas City	125
Roshan, Bijan	Mission, KS	126
Ross, Gilbert, Jr.	Columbia	026
Ross, Robert M.	Kansas City	125
Ross, William J.	Bridgeton	190
Roter, Alexander M.	St. Charles	189
Roth, Alfred D.	Mission, KS	125
Roth, John J.	St. Louis	190
Rother, Paul H.	St. Charles	189
Rotskoff, Kenneth S.	St. Louis	190
Rottler, Paul D.	St. Louis	190
Rouse, Ernest T.	St. Louis	190
Rouse, Ernest T., 111	St. Louis	190
Roush, Randall D.	Florissant	190
***Routsong, Rodney T.**	St. Louis	190
Roxas, Generoso P.	St. Charles	189
Roy, Tapankumar S.	St. Louis	190
Royce, Debra L.	Sarcoxie	102
Rozen, Jay 1.	Kansas City	125
Rubin, Brian G.	St. Louis	002
Rudloff, Mary A.	St. Louis	002
Rudolph, Joseph C.	Fenton	190
Ruehl, Albert F.	St. Louis	190
Rues, Lawrence A.	Kansas City	125
Ruess, Robert W.	Cape Girardeau	042
Ruff, Paul G.	Springfield	082
Rul-Lan, Carlos D.	Kansas City	002
Rumpf, Ronald P.	Columbia	026
Runez, Manuel W.	Maryville	158
***Rupright, S. Jon**	Columbia	058
Rush, Marvin R.	Ste. Genevieve	174
Russell, Garth S.	Palm Beach, FL	026
Russell, James L.	Kansas City	125
Russell, John J.	Cape Girardeau	042
Russell, Kimberly A.	Kansas City	126
***Russell, Robert B.**	Cape Girardeau	042
Russell, Robert K.	Kansas City	125
Russell, Steven L.	Kansas City	050
Rutherford, Barry D.	Kansas City	002
Rutlege-Baker, Kristie A.	O'Fallon, IL	195
Ruwitch, Joseph F., Jr.	St. Louis	190
Ryall, Jo-Ellyn M.	St. Louis	190
Ryan, David	Trenton	078
Ryan, Robert A.	Mission, TX	082
Ryan, Robert E., Sr.	Chesterfield	190
Ryan, Thomas J.	Jefferson City	058
Rymer, Marilyn M.	Kansas City	125
Ryser, Carol A.	Kansas City	125

S

Sabates, Felix N., Sr.	Prairie Village, KS	125
Sabates, Nelson R.	Prairie Village, KS	125
Sabates, Roland	Kansas City	125
Sabet, Abdollah A.	Ballwin	190
Saboeiro, Gregory R.	St. Louis	002
***Sacha, Robert F.**	Cape Girardeau	042
Sachar, Jerome D.	St. Louis	190
Sadhu, Vijay K.	Columbia	026
Saferstein, A. L.	Prairie Village, KS	125
Safley, Thomas J.	Independence	125
Saghir, Marcel T.	St. Louis	190

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Saha, Nitai C.	St. Louis	190
Saha, Sudha R.	St. Louis	190
Sahebjamei, Tannaz	Kansas City	126
Sahota, Pradeep K.	Columbia	026
Sakmar, Douglas A.	St. Louis	190
Salanga, Percival B.	St. Louis	190
Salazar, Berette A.	St. Louis	002
Sale, Llewellyn, Jr.	St. Louis	190
Salibi, Habbouba	Chesterfield	190
Salmon, M. L.	Palm Harbor, FL	190
Salvador, Antonio	St. Louis	190
Samet, John M.	St. Louis	190
Sammon, T. James	Springfield	082
Samson, Barry L.	St. Louis	190
Samudrala, Ramulu	St. Louis	190
Samudrala, Suseela	St. Louis	190
Samuel, George P.	Doniphan	034
Samuelson, Thomas S.	Kansas City	125
Sanchez, Archie J.	Kansas City	002
Sanchez, Jon J.	Springfield	082
Sanders, Harold L.	Gravois Mills	026
Sanders, Jack S.	Jefferson City	058
Sanders, William F.	Kansas City	125
Sandiford, Patrick	St. Charles	189
Sandow, Theodore L.	Kansas City	125
Sandza, Joseph G., Jr.	Des Peres	190
Saneman, Paul P.	Poteau, OK	102
Sanfelippo, John F.	Jefferson City	058
Santanello, William M.	Belleville, IL	190
Saradih, Hassan M.	Prairie Village, KS	126
Sargent, Alden P.	Sikeston	202
Sarma, Anuradha H.	Lee's Summit	125
Sasser, William F.	St. Louis	190
Sato, George	Chesterfield	190
Sato, Richard W.	Chesterfield	190
Satterlee, C. Craig	Kansas City	125
Sauer, Gordon C.	Kansas City	125
Savci, Hasan D.	St. Louis	190
Sawyer, Floyd E.	Ft. Lauderdale, FL	050
Sawyer, James	St. Louis	190
Scacewater, Rick	Joplin	102
***Scanlon, Robert C., II**	Springfield	082
Scarborough, Betty F.	Shawnee Mission, KS	125
Scarborough, Mark R.	Kansas City	125
Scearce, Robert L.	Jefferson City	058
Schaaf, Robert O.	St. Joseph	030
Schabbing, Mark B.	Columbia	027
Schaberg, James E.	St. Charles	189
Schaberg, Kevin B.	Chesterfield	190
Schaefer, Glennon S.	St. Louis	190
Schaeffer, Edward M.	Springfield	082
Schaerer, Jacques P.	St. Louis	190
Schane, Catherine L.	Springfield	082
Schanzlin, David J.	La Jolla, CA	190
Schaper, Ernest H.	St. Louis	190
Scharf, Daniel	Overland Park, KS	125
Scharrer, Alan J.	Holden	110
Scheibe, Robert G.	St. Louis	190
Scheible, Robert F.	St. Louis	190
***Schekorra, Fred W.**	Camdenton	058
Schell, James A.	Columbia	026
Scheperle, Mark A.	St. Louis	190
Schermer, Jerrold A.	Columbia	026
Scheu, James H.	St. Peters	190
Schewe, Elmer J.	Columbia	026
Schierman, William D.	St. Louis	190
Schiffmacher, Jack E.	Prairie Village, KS	125
Schillie, Gene A.	Kansas City	125
Schlafly, Bruce S.	St. Louis	190
Schlafly, Edward F., Jr.	Chesterfield	190
Schlansky, Howard J.	St. Charles	189
Schlansky, Seymour M.	St. Louis	190
Schlarman, David E.	St. Louis	190
Schleicher, Paul J.	Kansas City	126
Schlossman, David M.	Columbia	026
Schlozman, Daniel L.	Kansas City	125
Schmaltz, Richard A.	Columbia	026
Schmid, Tania L.	St. Louis	190
Schmidt, Dennis A.	St. Louis	190
Schmidt, Edwin H.	St. Louis	190
Schmidt, Edwin H., III	St. Louis	190
Schmidt, Herbert J.	Joplin	102
Schmidt, Jerome H.	Jefferson City	058
Schmidt, Martin P.	St. Louis	190
Schmidt, Thomas L.	Kansas City	125
Schmitz, John M.	Kansas City	125
Schmitz, Ralph A.	Monett	166
Schnarr, William	St. Charles	189
Schneider, Alan M.	Overland Park, KS	125
***Schneider, Horace L.**	Cape Girardeau	042
Schneider, J. Michael	Springfield	082
Schneider, Paul G.	St. Louis	190
Schneider, Robert J.	St. Louis	190
***Schneider, Robert P.**	Memphis	150
Schneider, Thomas A.	St. Charles	189
***Schnur, David**	Cape Girardeau	042
Schnurr, Thomas C.	Jefferson City	058
Schoch, Lawrence H.	Florissant	190
Schoedinger, George R., III	St. Louis	190
Schoenecker, Perry L.	St. Louis	190
***Schoenfeld, Roger H.**	Joplin	102
Schoengarth, Lowell D.	Columbia	026
Schondelmeyer, R. Wade	Columbia	026
Schoolman, Arnold	Kansas City	125
Schopp, Alvin C.	St. Louis	190
Schottman, Gerhard W.	Shawnee Mission, KS	125
Schrader, Jean	Olathe, KS	126
Schreiber, David J.	Alton, IL	190
Schrenk, Loren C.	St. Louis	190
Schrick, Richard E.	St. Louis	190
Schrodt, Rudolph	St. Louis	195
Schroeder, Walter A., Jr.	Cape Girardeau	042
Schroer, William C.	Bridgeton	002
Schroff, Carle E.	Springfield	082
Schuessler, Edward C.	St. Albans	190
Schuessler, Wolfgang P.	St. Louis	190
Schuetz, Alfred	St. Charles	189
Schuetz, Evelyne G.	St. Charles	189
Schuh, Marlys E.	Creve Coeur	190
Schultz, Earl R.	St. Louis	190
Schultz, Paul K.	St. Louis	190
Schulz, Richard C.	St. Louis	190
Schutz, John P.	Excelsior Springs	050
Schwartz, Henry G.	St. Louis	190
Schwartz, Howard I.	Kansas City	125
Schwartz, Howard R.	Springfield	082
Schwarz, Luis H.	St. Louis	190
Schwarze, Daniel J.	St. Louis	190
Schwegler, Robert G.	Shawnee Mission, KS	125
Schweiss, John F.	St. Louis	190
Sciortino, Robert A.	Bridgeton	190
Scodary, Daniel J.	Bridgeton	190
Scott, Andrew	Kansas City	125
Scott, C. Alan	Marshall	198
Scott, E. David	Jefferson City	058
Scott, Elwin P.	Sun City, AZ	190
Scott, Hillard L.	St. Louis	190
Scott, Jamie A.	Springfield	082
Scott, Joni C.	Springfield	082
Scott, Kenneth F.	Clinton	086
Scott, Michael R.	Springfield	082
Scott, Robert W.	Springfield	082
Scott, Wendell J.	Springfield	082
Scowley, John E.	Richmond	118
Scully, Thomas F.	St. Louis	190
Seabaugh, Janice L.	Cape Girardeau	042
Seabaugh, William L.	Cape Girardeau	042
Seaberg, John J., III	Columbia	026

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Seagrave, Richard A.	**082**	Springfield
Sears, John	**027**	Columbia
Sedgwick, William G.	**190**	St. Louis
See, W. Mike	**026**	Columbia
Seeck, Linda E.	**074**	Washington
Seeley, James J.	**190**	St. Louis
Seelig, Robert D.	**002**	St. Louis
Segraves, Steven D.	**125**	Kansas City
Seiden, Gerald D.	**125**	Kansas City
Seitz, Elson F.	**125**	Independence
Selhorst, John B.	**190**	St. Louis
Seligson, Frederic L.	**125**	Prairie Village, KS
Selove, Peter T.	**102**	Joplin
Sertl, George O.	**190**	St. Louis
Sertl, James F.	**190**	St. Louis
Sessions, Donald G.	**190**	St. Louis
Severance, Michael S.	**058**	Jefferson City
Shaeffer, James T.	**082**	Springfield
Shaffer, William O.	**190**	St. Louis
Shagets, Frank W.	**102**	Joplin
Shah, Anwar	**190**	St. Louis
Shah, Jitendra P.	**190**	St. Louis
Shah, Ramesh R.	**102**	Joplin
Shah, Riaz H.	**014**	Mexico
Shah, Sheila	**030**	St. Joseph
Shaheen, Eleanor	**026**	Columbia
Shakil, Mohammad	**042**	Cape Girardeau
Shalet, Malcolm F.	**125**	Kansas City
Shanahan, Mary P.	**102**	Joplin
Shanahan, Philip J.	**190**	St. Louis
Shands, Courtney, III	**190**	St. Louis
Shane, Ramon A.	**082**	Springfield
Shaner, Thomas P.	**190**	St. Louis
Shank, Robert E.	**190**	St. Louis
Shapero, James A.	**026**	Columbia
Shapleigh, John B., II	**002**	Chesterfield
Shaplin, Alfred D.	**106**	Ballwin
Sharlow, Joseph W.	**174**	Ste. Genevieve
***Sharp, David G.**	**030**	St. Joseph
Sharp, Jeffrey A.	**178**	Sedalia
Sharp, Ronald J.	**125**	Overland Park, KS
Shatz, Burton A.	**190**	St. Louis
Shaw, Edward J.	**190**	St. Louis
Shaw, James T.	**074**	Hermann
Shaw, Richard C.	**190**	St. Louis
Shaw, Robert D.	**206**	Willow Springs
Shea, James G.	**074**	Hobe Sound, FL
Sheahan, Peggy K.	**195**	St. Louis
Sheahon, John A.	**125**	Raytown
Shealy, C. Norman	**082**	Fair Grove
Shearer, Robert D.	**058**	Jefferson City
Shechter, Nathan	**125**	Overland Park, KS
Sheehan, Michael B.	**125**	Kansas City
Sheehan, Paul J.	**190**	Bridgeton
Sheffner, Paul W.	**190**	St. Louis
Shelden, Russell D.	**125**	Kansas City
Shell, William C.	**202**	Sikeston
Shelley, James M.	**082**	Springfield
Shelley, William C.	**125**	Kansas City
Shelton, Becky R.	**190**	Chesterfield
Shelton, Earl W.	**190**	Lake St. Louis
Shelton, R. Wayne	**082**	Springfield
Shen, Anthony S.	**190**	St. Louis
Shen, Jerome T.	**190**	St. Louis
Shen, Winston W.	**190**	St. Louis
Sher, Allyn L.	**026**	Columbia
Sheridan, John J.	**190**	St. Louis
Sherman, David M.	**082**	Springfield
Sherman, W. Gary	**190**	Chesterfield
Sherrod, Duane W.	**102**	Joplin
***Sherrod, Glenn M.**	**190**	Bridgeton
Sherwin, Charles S.	**190**	St. Louis
Shevlin, Charles F.	**030**	Palm Springs, CA
Shields, John B.	**190**	St. Louis
Shields, Lawrence S.	**082**	Springfield
Shifrin, Alexander	**125**	Kansas City
Shimshak, Thomas M.	**125**	Kansas City
Shine, Thomas E.	**190**	St. Louis
Shinn, Michael E.	**050**	Kansas City
***Shipman, Wade M.**	**082**	Rogersville
Shitut, Ravindra V.	**190**	St. Louis
Shively, Robert A.	**190**	St. Louis
Shniter, Lorinna	**190**	St. Louis
Shockley, Clarence J.	**125**	Greenwood
Shopper, Glenn K.	**125**	Kansas City
Shopper, Moisy	**190**	St. Louis
Shore, Jeffrey L.	**102**	Joplin
Short, Charles D.	**190**	St. Louis
Short, Howard N.	**074**	Washington
Shoss, Milton	**042**	Hilton Head Island, SC
Shoults, Nicholas F.	**082**	Springfield
Shriver, Rebecca L.	**126**	Kansas City
Shuler, Frederick N.	**125**	Kansas City
Shull, G. D.	**058**	Jefferson City
Shultz, Thomas M.	**082**	Springfield
Shuman, Joseph S.	**190**	St. Louis
Shuman, Mary	**126**	Mission, KS
Shuss, David H.	**125**	Kansas City
Shuter, Eli	**190**	St. Louis
Shuttari, Mir F.	**190**	St. Louis
Shyken, Herman	**190**	St. Louis
Sicard, Gregorio A.	**190**	St. Louis
Sicat, Alfonso V.	**110**	Warrensburg
Sides, Stanley D.	**042**	Cape Girardeau
Siegel, Barry A.	**190**	St. Louis
Siegel, Carl D.	**125**	Kansas City
Siegel, Charles	**050**	Gladstone
Siegfried, Carla J.	**190**	Ballwin
Siemer, Deanna M.	**027**	Columbia
Siemers, George E.	**190**	Naples, FL
Sigmund, Charles A.	**190**	Bridgeton
Sigmund, Charles J., Jr.	**190**	St. Louis
Silbergeld, Daniel L.	**190**	St. Louis
Siler, Thomas M.	**189**	St. Charles
***Sill, William**	**189**	St. Peters
Silliman, York E.	**030**	St. Joseph
Silsby, Harry D.	**082**	Springfield
Silver, Bernd	**190**	St. Louis
Silver, Donald	**026**	Columbia
Silverberg, Charles	**190**	St. Louis
Silvers, L. Michael	**125**	Kansas City
Silverstein, Randy B.	**190**	St. Louis
Silverstein, Steven M.	**125**	Kansas City
Simmons, Connie D.	**042**	Cape Girardeau
Simmons, Donald D.	**125**	Kansas City
Simmons, Jess S.	**102**	Joplin
Simmons, John L.	**125**	Cashiers, NC
Simo, Frank	**190**	St. Louis
Simon, David L.	**190**	St. Louis
Simon, Nathan M.	**190**	St. Louis
Simon, Sanford	**125**	Shawnee Mission, KS
Simowitz, Fredric M.	**189**	St. Charles
Simpson, Albert P.	**082**	Springfield
Simpson, Joseph R.	**190**	St. Louis
Sincox, Charles H.	**074**	Washington
Sindhwani, Ravinder K.	**150**	Louisiana
Singh, Daljeet R.	**118**	Higginsville
Singh, Kuldeep	**046**	Macon
Singleton, Charles M., II	**125**	Kansas City
Singleton, Marvin A.	**102**	Joplin
Siripipat, Pallop	**014**	Mexico
Siriwangchai, Kulnarin G.	**126**	Kansas City, KS
Sisillo, Sabato	**126**	Lee's Summit
Sislen, Donald R.	**190**	St. Louis
Sisson, Richard G.	**190**	St. Louis
Sistrunk, William W.	**002**	Springfield
Sitzman, Everette T.	**125**	Kansas City
Sitzmann, Bryan L.	**050**	Kansas City

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Siu, Kenneth K.C.	Jefferson City	058
Sivarajan, Subramanian	Kansas City	125
Skeins, Edward J., Jr.	Springfield	082
Skelley, Mark J.	Joplin	102
Skillman, Robert K.	Shawnee Mission, KS	125
Skimming, W. Lee	St. Louis	190
Skinner, John S.	Chesterfield	190
Sklenar, Donald E.	St. Joseph	030
Slack, Melinda R.	Springfield	082
Slagle, Genelle J.	Merriam, KS	126
Slahorek, George J.	St. Joseph	030
Slankard, J. Edward	Overland Park, KS	125
Slaughter, Carl R.	Morrilton, AR	050
Slaughter, Larry	Columbia	026
Slentz, Edwin L.	Shawnee Mission, KS	125
Sleuwen, Leslie	St. Louis	190
Slocum, Stephen G.	St. Louis	190
Sly, Anne K.	Kansas City	125
Smalley, Stephen R.	Kansas City	125
Smalling, Ronnie G.	Springfield	082
Smeltzer, Frederick M.	Osage Beach	120
Smid, David M.	Springfield	082
Smiley, William L.	St. Louis	190
Smith, Arnold L.	Columbia	026
Smith, Arthur B.	Philadelphia, PA	125
Smith, Benjamin F.	St. Louis	190
Smith, Brenda S.	Kansas City	125
Smith, Bruce D.	St. Joseph	030
***Smith, C. Daniel**	St. Joseph	030
Smith, Carol A.	St. Louis	195
***Smith, Charles H.**	Gladstone	050
Smith, Claude F.	Willow Springs	206
Smith, Courtland P., Jr.	Kennett	070
Smith, David L.	Kansas City	125
Smith, Dermott A.	St. Louis	190
Smith, Earl E., III	St. Louis	190
Smith, Edward B.	Kansas City	125
Smith, Emily L.	St. Louis	190
Smith, Gilbert D.	Poplar Bluff	034
Smith, Hubert E.	Kansas City	125
Smith, Hugh R.	St. Louis	190
***Smith, James D.**	Kirksville	148
Smith, Katherine W.	Kansas City	125
Smith, Kathleen	DuQuoin, IL	190
Smith, Kenneth B.	Washington	074
Smith, Kenneth R.	Bolivar	206
Smith, Kenneth R., Jr.	St. Louis	190
Smith, Kristy	Kansas City	126
Smith, Melissa L.	Kansas City	126
Smith, Norman A.	Columbia	026
Smith, Patrick A.	Columbia	026
Smith, Peter G.	St. Louis	190
Smith, Porter	Poplar Bluff	070
Smith, Reid C.	Kansas City	125
Smith, Robert W.	Brookfield	078
Smith, Robert W.	Chesterfield	190
Smith, Roland T.	Gulfport, MS	102
Smith, Sally L.	Chesterfield	190
Smith, Timothy W.	Kansas City	125
***Smith, Toni R.**	Kirksville	148
Smith, Victorija L.	Springfield	082
Smith, W. Russell	Carthage	102
Smith, Wallace B.	Independence	125
Smith, William J.	Windsor	086
Smoller, Martin B.	St. Louis	189
Snead, William H.	Springfield	082
Sneid, David S.	Kansas City	125
Snidle, William F.	Crystal City	106
Snow, Emasue	Springfield	082
Snow, Jon F.	Springfield	082
Snowden, Kent L.	St. Louis	190
Snyder, Charles L.	Overland Park, KS	125
Sobky, George H.	Louisiana	190
***Soghrati, Naser O.**	Kansas City	126
Soha, Joseph J., Jr.	Columbia	026
Sohn, Richard	St. Louis	190
Solanki, Nareshkumar J.	Wentzville	190
Sollars, Eric G.	St. Joseph	030
Solomon, Steven L.	Chesterfield	190
Soltys, Stephen M.	Columbia	026
Sommer, Conrad S.	St. Louis	190
Sommer, Rand W.	St. Louis	002
Sommer, Ross B.	St. Louis	190
Song, James	Chesterfield	195
Soonattrakul, Wuthisak	Kennett	070
Soorya, Narendir T.	St. Louis	190
Sopuch, John A.	St. Louis	190
Sosebee, Lee A.	Hot Springs, AR	026
Sosna, Jacob P.	St. Louis	190
Soucy, John C.	St. Charles	189
Southgate, Theodore J.	Cape Girardeau	042
Southwick, Christopher L.	Columbia	026
Spadaro, James J.	St. Louis	190
Spade, Diana J.	Springfield	082
Spadone, Donald P.	Columbia	026
Spaedy, Tony	Columbia	026
Spake, R. Vanneman	Kansas City	125
Spalding, David L.	Rogersville	082
Spalding, Donald G.	St. Louis	190
Sparkman, Thomas C.	Cape Girardeau	042
Spector, Gershon	St. Louis	190
Spellman, Michael J., Jr.	St. Louis	195
Spence, Paul A.	Cape Girardeau	042
Spence, Paul R.	Kansas City	126
Speno, Angelo A.	St. Louis	190
Spernoga, John F.	St. Louis	190
Spinzig, Bruce D.	Moberly	046
Spitler, Allen L.	Cape Girardeau	042
Sponenberg, Don D.	Springfield	082
Sportsman, Weldon L.	Kansas City	050
Sprague, Gita	St. Joseph	030
Spurgat, Robert M.	St. Joseph	030
Spurgeon, Milo J.	Columbia	026
Spurlock, Luther D.	Rolla	135
Spurney, Joe E.	Kansas City	125
Spurny, Otto M.	Kansas City	125
Spurrier, Mark H.	St. Louis	190
Squitieri, Alphonse J.	St. Louis	190
St. John, Donald R.	Marshall	102
St. Peter, David A.	Kansas City	126
Stacey, Wallace R.	Independence	125
Stafford, Walter R.	St. Louis	190
Stahl, Lloyd D.	Overland Park, KS	125
***Stahly, Randall L.**	Cape Girardeau	042
Stahr, William D.	Cape Girardeau	042
Stallard, Donald J.	St. Joseph	030
Stamatis, John J.	Springfield	082
Stamps, Gregory S.	Springfield	082
Standiford, Steven B.	Columbia	026
Stanley, Brad K.	Independence	125
Stanley, Charles G.	Kansas City	125
Stansfield, Julie D.	Columbia	026
Stark, Karl R.	Kansas City	125
Stark, William H.	Kansas City	125
Starke, Keith M.	St. Louis	190
Starks, Gregory C.	Kansas City	125
Starr, Steven K.	N. Kansas City	125
Statland, Harry	Kansas City	125
Statland, Morris	Shawnee Mission, KS	125
Stauffer, Larry K.	Jefferson City	058
***Steele, Brian K.**	Joplin	102
Steele, Jack T.	Bridgeton	190
Steele, Mark T.	Kansas City	002
Steenbergen, Michael	Jefferson City	058
Steffen, Lawrence F.	Shawnee Mission, KS	125
Steiling, Sylvia A.	St. Louis	190
Steiman, Barry	St. Charles	189
Stein, Bernard	Joplin	102

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Steinberg, Franz U. St. Louis	**190**
***Steinbrecher, Janis M.** Lee's Summit	**125**
Steiner, Alexander J. St. Louis	**190**
Steiner, Marvin P. Independence	**125**
Steinhaus, David M. Kansas City	**125**
Steinvurzel, Mark D. St. Louis	**195**
Stelmach, Walter J. Kansas City	**125**
Stenberg, Michael D. Dubuque, IA	**050**
Stephen, C. Ronald Chesterfield	**190**
Stephenson, Hugh E. Columbia	**026**
Stephenson, William T. Kansas City	**125**
Sterkel, Barbara B. St. Louis	**190**
Sterkel, Richard L. St. Louis	**190**
Stetson, William B. St. Louis	**190**
Stevens, Edward M. St. Joseph	**030**
Stevens, Sheridan Independence	**125**
Stewart, Angela R. Columbia	**026**
Stewart, Harry A. Kansas City	**125**
Stewart, James G. St. Louis	**190**
Stewart, James L. Kansas City	**050**
Stewart, L. Paul St. Louis	**190**
Stewart, Robert B. Springfield	**082**
Stiaszny, Louis K. Kansas City	**125**
Stickle, Arthur W. St. Louis	**190**
Stickley, Louis P. St. Louis	**190**
Stiene, Henry A. Joplin	**102**
Stiles, Michael C. Kansas City	**125**
Stiles, Michella M. Kansas City	**125**
***Stillie, G. Donald** Kansas City	**125**
Stillings, Wayne A. St. Louis	**190**
Stith, John A. St. Louis	**190**
Stocklin, Catherine St. Louis	**195**
Stockton, Raymond W. Shawnee Mission, KS	**125**
Stockwood, Robert C. Sedalia	**178**
Stoecker, Willeford J. Cape Girardeau	**042**
Stoecker, William V. Rolla	**135**
Stoffa, Maureen E. St. Louis	**190**
Stohr, Paul E. St. Charles	**190**
Stokes, Douglas L. St. Joseph	**030**
Stokes, James M. St. Louis	**190**
Stolar, Cary G. St. Louis	**190**
Stoliar, John B. St. Louis	**190**
Stone, Kenneth D. Sikeston	**202**
Stoneman, William, III St. Louis	**190**
Stoops, Stephen L. Kansas City	**125**
Stout, Carl N. Independence	**125**
Stout, Tim Shawnee, KS	**126**
Stover, Paul M. Overland Park, KS	**125**
Stoy, Robert P. Columbia	**026**
Stradford, H. Todd Columbia	**026**
Strain, Herb A. Kansas City	**125**
Strasberg, Steven M. St. Louis	**190**
Stratemeier, Edward H. Blue Springs	**125**
Straub, David L. Joplin	**102**
Strauss, Carl F. Kansas City	**125**
Strecker, William B. St. Louis	**190**
Streiff, Maria G. St. Louis	**190**
Stricker, William E. Rolla	**135**
Strickland, James C. St. Louis	**190**
Stringer, Kenton L. Aurora	**166**
***Stringer, Robert F.** Joplin	**102**
Strobach, Kurt F. St. Louis	**190**
Stroble, Mark St. Louis	**190**
Stromberg, Brent V. St. Louis	**190**
Stromberg, Eric D. Kansas City	**125**
Strong, Alexandra J. Kansas City	**125**
Stronsky, David St. Louis	**190**
Stroud, Malcolm H. Dallas, TX	**190**
Stryker, William I. Osprey, FL	**190**
Stuart, Byron M. Boonville	**026**
Stuart, Daniel D. Brunswick	**046**
Stuart, Wallace E. St. Louis	**190**
Stubbs, Thomas R. West Plains	**206**
Stuber, Robert R. St. Joseph	**030**
Stuerman, Lawrence G. Louisiana	**150**
Stufflebam, Robert E. Springfield	**082**
Stuppy, Mark S. Springfield	**082**
Stuppy, Robert J. Joplin	**102**
Sturtevant, Harwood N. Springfield	**082**
Su, Philo S. Jefferson City	**058**
Suarez, Alberto Lee's Summit	**125**
Suarez-Solar, Pedro L., Jr. St. Louis	**190**
Subramanian, S. Carthage	**102**
Sudekum, Anthony E. Defiance	**189**
Sudekum, Joseph M. St. Louis	**190**
Sueper, Robert H. St. Louis	**190**
Sugarbaker, Everett D. Jefferson City	**058**
Sugarbaker, Stephen P. Jefferson City	**058**
Suk, Samuel Kansas City	**126**
Sullivan, Andrea J. Kansas City	**126**
Sullivan, Bradley H. Kansas City	**125**
Sullivan, Christine Overland Park, KS	**125**
Sullivan, Clement J. St. Louis	**190**
Sullivan, Dan T. Springfield	**082**
Sullivan, David M. Springfield	**082**
Sullivan, John A. Springfield	**082**
Sullivan, William W. St. Louis	**190**
Sultan, Tipu Florissant	**190**
Sultana, Peter Columbia	**027**
Sumer, Emel A. Bridgeton	**190**
Summerfield, Anita Springfield	**206**
Summers, John B. St. Louis	**190**
Summers, Joseph S. Sun City, AZ	**058**
Summers, Thomas F. Olney, IL	**190**
Sun, Belinda Fairway, KS	**126**
Sundaresan, Sudhir St. Louis	**002**
Sunderji, Shiraz St. Louis	**190**
Sundstrom, Frank D. Springfield	**082**
Sundt, Thoralf M. St. Louis	**002**
Sunshine, Herbert St. Louis	**190**
Suseela, Dasari Kansas City	**125**
Susi, Jesse G. St. Louis	**190**
Sutherland, Charles J. Ottawa Hills, OH	**190**
***Suthoff, Jim** Joplin	**102**
Sutphen, Eric J. St. Louis	**190**
Sutter, Richard A. St. Louis	**190**
Sutton, Matthew B. Kansas City	**126**
Sutton, Trevor S. St. Louis	**002**
Suwannasri, Rudee St. Louis	**190**
Svancarek, William P. St. Louis	**190**
Swaim, Truett Blue Springs	**125**
Swan, Kia L. Florissant	**195**
Swaney, Charles M. Columbia	**026**
Swango, J. Scott Springfield	**082**
***Swanson, Michael J.** Columbia	**026**
Swanson, Robert G. Ocean Springs, MS	**002**
Swaykus, Bernard T. Bridgeton	**190**
Sweeney, Michael J. Kansas City	**125**
Sweeney, Thomas P. Springfield	**082**
Sweiger, James H. Plattsburg	**054**
Swinfard, Ronald W. Columbia	**026**
Switzner, Diane L. Springfield	**082**
Sylvanovich, W. Richard St. Louis	**190**
Szabados, Ernest D. Independence	**125**
Szewczyk, Michael J. Columbia	**026**
Szoko, Edward St. Louis	**190**
Szymanski, Stanley R. Macon	**078**

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Tackitt, Bobby O., II Poplar Bluff	**034**
Tackitt, Kimberly D. Poplar Bluff	**034**
Taege, Alan J. St. Joseph	**030**
Tailor, Chandrakant C. St. Louis	**190**
Takacs, Robert J. Kansas City	**125**
Talbert, Clifford R. Cape Girardeau	**042**
Tamblyn, Claire L. Tubac, AZ	**125**
Tang, Teodoro Salem	**135**
Tanner, John P. Kansas City	**125**
Tanner, Robert H. Jefferson City	**058**

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***Tanner, Scott W.**	058	Jefferson City
Tanphaichitr, Kongsak	190	St. Louis
Tansuwan, Chukiat	190	St. Louis
Taormina, Marc K.	125	Independence
Tariq, Manzoor A.	190	Chesterfield
***Tarwater, James K.**	050	Kansas City
Tate, Kara L.	125	Kansas City
Tatini, Paparao	002	St. Louis
Taute, Hermann	190	St. Louis
Taylor, Eugene D.	190	St. Louis
Taylor, John R.W.	125	Independence
Taylor, Leon A.	058	Jefferson City
Taylor, Philip W.	042	Cape Girardeau
Taylor, Steve J.	014	Mexico
Taylor, William K.	082	Springfield
Teague, J. Lynn	026	Columbia
Teff, Richard J.	027	Columbia
Tegeler, Kent E.	050	Liberty
Tegtmeyer, Chris	115	Lebanon
Tekwani, Hiralal T.	190	St. Louis
Tellerman, Barbara J.	026	Columbia
Templer, Jerry W.	026	Columbia
Tendai, Mark M.	082	Springfield
Tenniswood, Christine M.	126	Kansas City
Tenorio, Arturo A.	158	Stanberry
Tenorio, Genoveva	158	Albany
Tepper, Arnold	190	St. Louis
***Terpstra, Gregory K.**	138	Potosi
Terry, Boyd E.	026	Columbia
Terry, James F.	082	Springfield
Terry, James W.	042	Cape Girardeau
Terschluse, David A.	190	Bridgeton
Tess, Allen F.	190	Florissant
Tessier, John E.	190	St. Louis
***Tewis, Huey D.**	042	Cape Girardeau
Thaker, Jayesh	126	Kansas City
Thal, Sanford M.	190	St. Louis
Thalblum, Harvey	125	Kansas City
Thale, Thomas R.	190	Ballwin
Thawley, Stanley E.	190	St. Louis
Theby, Janet E.	058	Eldon
Thedinger, Bradley S.	125	Kansas City
Theel, Otto W., Jr.	125	Shawnee Mission, KS
Thesing, John A.	125	Lenexa, KS
Thibeault, Donald W.	125	Kansas City
Thiel, J. Allen	190	St. Louis
Thiele, Belmont R.	190	Las Vegas, NV
Thiele, Otto K.	189	St. Charles
Thierauf, Charles G.	190	St. Louis
Thies, Jerome H.	214	Osceola
Thoma, George E., Jr.	190	St. Louis
Thomas, Alexis G.	125	Kansas City
Thomas, Christopher Y.	125	Shawnee Mission, KS
Thomas, Deborah G.	042	Cape Girardeau
Thomas, F. Anthony	050	Kansas City
Thomas, Horace E.	026	Columbia
Thomas, J. Regan	190	St. Louis
Thomas, James J.	125	Kansas City
Thomas, Jonathan L.	042	Cape Girardeau
Thomas, Leslie D.	050	N. Kansas City
Thomas, Matthew A.	190	St. Louis
***Thomas, Norvin E.**	014	Mexico
Thomas, Robert M.	026	Columbia
Thomasson, David D.	082	Springfield
Thomasson, Jeffrey L.	190	St. Louis
Thomasson, Mary W.	190	St. Louis
Thompson, David E.	125	Lee's Summit
Thompson, F. Gregg	030	St. Joseph
Thompson, Frederick E.	050	Liberty
Thompson, Frederick L.	214	Nevada
Thompson, James E.	206	West Plains
Thompson, M. Bryant	190	Chesterfield
Thompson, Paul D.	042	Cape Girardeau
Thompson, Paul H.	208	Branson
Thompson, Randall C.	125	Shawnee Mission, KS
Thompson, Robert F.	125	Kansas City
Thompson, Robert W.	190	St. Louis
Thompson, Scott W.	125	Kansas City
Thomure, Michael F.	002	St. Louis
Thornton, Fred H.	202	Sikeston
Thornton, Michael K.	106	St. Peters
Thorpe, William P.	042	Cape Girardeau
Threlkeld, Kevin L.	002	Lake St. Louis
Throne, Ben J.	125	Kansas City
Thurmann, Manfred	190	Chesterfield
Thyssen, Erik P.	190	St. Louis
Tice, Wayne K.	125	Lee's Summit
Tichenor, Robert W.	190	Fenton
Tiefenbrunn, Sharon F.	190	St. Louis
Tiemann, James H.	126	Lee's Summit
Tietjen, Fred O.	120	Osage Beach
Till, Bennie N.	034	Poplar Bluff
Tillema, David A.	125	Kansas City
Tillman, Mary A.	190	St. Louis
Tilson-Mallett, Nancy R.	125	Kansas City
Tilzer, Seth	190	Florissant
Tindall, Robert N.	190	Punta Gorda, FL
Tinger, Alfred	195	Ballwin
Tinsley, John C.	026	Columbia
Tiojanco, Milagros E.	125	Kansas City
Tippett, Jack C.	190	St. Louis
***Tipton, Richard J.**	042	Cape Girardeau
Titterington, Frank W.	125	Kansas City
Tjandra, Sarikun	126	Roeland Park, KS
Tobey, Albro C., Jr.	190	St. Louis
Tobin, Gregory A.	042	Cape Girardeau
Tobin, Marla J.	110	Warrensburg
Tobin, Robert F.	030	St. Joseph
Tobler, Jerry	190	Chesterfield
Tobler, Randall W.	190	St. Louis
Tolan, Robert W., Jr.	190	St. Louis
Tompson, Richard G.	206	West Plains
Tompson, Robert V.	046	Moberly
Torontow, R. John	214	Nevada
Torrence, Ralph J.	190	Chesterfield
Totty, William G.	190	St. Louis
Toubes, Daniel B.	125	Kansas City
Towle, Dana R.	050	Kansas City
Towle, Daniel J.	125	Kansas City
Toy, Karen L.	178	Sedalia
Trachtenberg, Jeffrey D.	195	St. Louis
Trammell, Lee W.	026	Columbia
Traxel, William L.	034	Poplar Bluff
Treacy, Bryan J.	066	Bolivar
Treadwell, Randall E.	190	Chesterfield
Trecha, Randal R.	026	Columbia
Tremblay, Gerald F.	002	Kansas City
Trentham, Orin P., III	102	Joplin
Trevor, Richard P.	125	Kansas City
Triantafillou, Anastasios	190	St. Louis
Trikha, Ajit	002	Belleville, IL
Trimble, Christopher P.	126	Overland Park, KS
Trimble, George X.	125	Kansas City
Trinidad, Hermanito R.	078	Chillicothe
Triplett, Daniel A.	050	Liberty
Triska, Roland A.	190	St. Louis
Tritz, Denise M.	058	Jefferson City
Tritz, James F.	058	Jefferson City
Troeh, Melvin R.	125	Independence
Troop, Bryan R.	190	St. Louis
Trotta, Philip C.	190	St. Louis
Trotter, Francis O., Jr.	190	Carrollton
Trotter, W. Yates	082	Springfield
Troug, William E.	125	Kansas City
True, James D.	050	Kansas City
True, John H.	034	Poplar Bluff
Trueblood, Alva C.	190	St. Louis
Trueblood, Michael C.	042	Cape Girardeau

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Trugly, Edith S.	190	St. Louis
Trumbower, William D.	026	Columbia
Trygg, Kelly A.	066	Bolivar
Tsai, Linda	195	St. Louis
Tsang, John L.	082	Honolulu, HI
Tschudin, Garland	190	St. Louis
Tsifutis, Argyrios A.	190	St. Louis
Tuck, Janna M.	042	Cape Girardeau
Tucker, Dolores R.	190	Chesterfield
Tucker, George L.	190	Chesterfield
Tucker, Leslie E.	074	Washington
Tucker, Robert E.	190	St. Louis
Tungsiripat, Soros	070	Kennett
Tuohy, Gerald F.	125	Kansas City
Tuohy, Stephen E.	125	Kansas City
Tupper, Joel	102	Joplin
Turano, William L.	125	Raytown
Turfboer, Robert	102	Greenville, NC
Turgeon, Ronald P.	190	St. Louis
Turnbaugh, Thomas R.	058	Jefferson City
Turner, Glenn O.	082	Springfield
Turner, James D.	074	Washington
Turner, Jane W.	195	Webster Groves
Turner, Kirby L.	034	Poplar Bluff
Turner, Michael L.	034	Poplar Bluff
*Turner, Timothy T.	002	Barrington, IL
Turner, William A.	214	Nevada
*Turpin, F. Duane	190	Bridgeton
Tutar, Ali	126	Kansas City
Tutera, Dominic F.	125	Kansas City
Tuttle, Jay F.	138	Creve Coeur
Tyler, Thomas D.	118	Richmond

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Uchiyama, Robert C.	190	Chesterfield
Uhlemann, John H.	189	St. Charles
Uhlemeyer, Henry A.	190	St. Louis
Uhrig, Jack R.	198	Marshall
Uketui, Ozoemenam I.	030	St. Joseph
Umar, Ibrahim S.	189	St. Peters
Underwood, Dick H.	125	Leawood, KS
Underwood, Johnson, III	050	N. Kansas City
Ungvari, Joseph C.	190	St. Louis
Unwin, Donald R.	190	St. Louis
Upadhyay, Ajay K.	138	Fredericktown
*Upton, Gary L.	026	Columbia

V

Vacca, Joseph B.	190	St. Louis
Vajaranant, Manit	118	Lexington
*Vale, Janett A.	125	Kansas City
Vale, Janie R.	026	Columbia
Valera, Salvador S.	030	St. Joseph
Vallurupalli, Vijayalakshmi	190	Bridgeton
Valtierra, Cesar A.	190	Ballwin
Valuck, Richard P., Jr.	150	Hannibal
Van Amburg, Albert L., III	190	Chesterfield
Van Biber, James T.	125	Independence
Van Buren, Wilbur D.	002	Kansas City
Van Buskirk, William C.	125	Shawnee Mission, KS
Van Dyke, Elmer H.	178	Sedalia
Van Norman, Robert T.	190	St. Louis
Van Ryn, Jacques S.	190	Bridgeton
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Vandivort, Paul M., Jr.	190	St. Louis
Vandover, John T.	190	St. Louis
Vannier, Michael W.	190	Iowa City, IA
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Varma, Devendra K.	034	Poplar Bluff
Vas, Wenzel G.	190	St. Louis
Vaughan, Mark	126	Kansas City
Vaughn, James W.	125	Overland Park, KS
Vazquez, Jose L.	002	Florissant
Vedder, Kathryn N.	190	St. Louis
Veitch, John M.	102	Joplin
Velander, Robert D.	125	Blue Springs
Velasco, Ernesto T.	190	St. Louis
Vellek, Mark J.	026	Columbia
Venneman, Charles R.	125	Kansas City
*Venter, John L.	102	Joplin
Ver Dught, Ammon L.	125	Independence
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Vest-Mason, Mary	195	Clayton
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Vidals, Victor G.	125	Kansas City
Vierling, Stephen E.	190	St. Louis
Viers, Wayne A.	190	St. Louis
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Vigneron, Eugene A.	058	Jefferson City
Vijungco, Jose G.	190	St. Louis
Villafuerte, Nila A.	190	St. Louis
Villahermosa, Juanito L.	010	Savannah
Villamar, Elizabeth N.	190	St. Louis
Villanueva, Angela A.	125	Overland Park, KS
Villarama, Antonio P.	190	High Ridge
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Vilmer, Stephen E.	050	N. Kansas City
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Vitale, Stephen J.	190	Chesterfield
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Viviano, Joseph G.	190	Glendale
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Vournas, George C.	190	Bridgeton

W

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Wadsworth, Harry L.	190	St. Louis
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Wagner, John R.	190	St. Louis
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Walker, Gary K.	082	Springfield
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Walker, J. Leslie	190	St. Louis
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Walker, William M.	082	Rogersville
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Wall, Leonard A.	125	Kansas City
Wall, Norman R.	082	Springfield
Wallace, Darryl L.	125	Kansas City
Walley, Lynn J.	150	Hannibal
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Walsh, Richard J.	030	St. Joseph
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Wankum, Robert P.	058	Jefferson City
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Ward, Mark R.	082	Springfield
Wardell, M. Annette	082	Springfield
Waring, J. Michael	125	Kansas City
Warren, Ronda L.	126	Kansas City, KS
*Wasserman, Gary S.	125	Kansas City
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Wathanacharoen, Suchint	125	Kansas City
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Watson, Timothy B.	026	Columbia
Watson, Trevor F.	026	Columbia
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Watts, Samuel M.	166	Mt. Vernon
Wax, Martin B.	190	St. Louis
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Waxman, Jane Z.	125	Lenexa, KS
Waxman, Joel E.	082	Springfield
Wayne, Sherwyn J.	190	St. Louis
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Webb, John M.	125	Kansas City
Webb, Karen B.	190	St. Louis
Webb, Paul B., Jr.	190	St. Louis
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Weinand, Ernest E.	030	Tucson, AZ
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Wester, William T.	042	Cape Girardeau
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Westerman, Robert N.	190	St. Louis
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Westfall, Susan H.	190	Chesterfield
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Wetzel, Gus S.	086	Clinton
Wexler, Stephen A.	190	St. Louis
Weyerich, Noel F.	190	St. Louis
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Wheeler, Charles B.	125	Kansas City
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Whitacre, Marc M.	125	Prairie Village, KS
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White, Bruce I.	190	St. Louis
White, Charles H.	125	Shawnee Mission, KS
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White, William L.	125	Kansas City
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Wiant, James R.	190	St. Louis

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Wilkinson, Everett A.	125	Prairie Village, KS
Wilkinson, Linda	125	Kansas City
Willcoxon, Robert L.	102	Joplin
Williams, C. Mark	125	Kansas City
Williams, Carol F.	190	St. Louis
Williams, Craig W.	042	Cape Girardeau
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Williams, John R., Jr.	189	St. Charles
Williams, John W., IV	082	Springfield
Williams, Joseph	190	St. Louis
Williams, Joseph C.	125	Shawnee Mission, KS
Williams, Paul A.	125	Kansas City
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Williams, R. Jerome, Sr.	190	St. Louis
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Willman, Vallee L.	190	St. Louis
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Wilson, Roy E.	082	Springfield
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Wilson, Timothy A.	050	Kansas City
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Wilucki, Melvin R.	190	St. Louis
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Winer, Nathaniel	125	Kansas City
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Wise, George W.	125	Shawnee Mission, KS
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Withrow, John B.	050	Kansas City
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Wittmer, Marc R.	082	Springfield
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Wolff, Dolores P.	190	Chesterfield
Wolff, Gerald A.	190	St. Louis
Wolff, Harold D.	190	St. Louis
Wolski, James R.	082	Springfield
Womack, Stephanie E.	026	Columbia
Won, Russell	190	St. Louis
Wonder, Donald	208	Branson
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Wood, John A.	190	Chesterfield
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Woody, Matthew B.	125	N. Kansas City
Wool, Gerald	190	St. Louis
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Wyrsch, Robert B.	082	Springfield

Y

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Yanow, Mitchell	190	St. Louis
Yap, Mardonio J.	190	Florissant
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Yates, Charles L.	026	Columbia
Yates, John M.	058	Jefferson City
Yates, Karen	042	Cape Girardeau
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Z

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Primary Specialty Codes

A	Allergy
ABS	Abdominal Surgery
ADL	Adolescent Medicine
AI	Allergy & Immunology
AM	Aerospace Medicine
AN	Anesthesiology
BE	Broncho-Esophagology
BLB	Bloodbanking
CCM	Critical Care Medicine
CD	Cardiovascular Disease
CDS	Cardiovascular Surgery
CHN	Child Neurology
CHP	Child Psychiatry
CLP	Clinical Pathology
CRS	Colon & Rectal Surgery
D	Dermatology
DIA	Diabetes
DMP	Dermatopathology
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology
FOP	Forensic Pathology
FPS	Facial Plastic Surgery
FP	Family Practice
GE	Gastroenterology
GER	Geriatrics
GP	General Practice
GPM	General Preventive Medicine
GS	General Surgery
GYN	Gynecology
HEM	Hematology
HNS	Head & Neck Surgery
HS	Hand Surgery
HYP	Hypnosis
ID	Infectious Diseases
IG	Immunology
IM	Internal Medicine
LAR	Laryngology
LM	Legal Medicine
MFS	Maxillofacial Surgery
MFM	Maternal & Fetal Medicine
N	Neurology
NA	Neuropathology
ND	Neoplastic Diseases
NEP	Nephrology
NM	Nuclear Medicine
NPM	Neonatal-Perinatal Medicine
NR	Nuclear Radiology
NS	Neurological Surgery
OBG	Obstetrics & Gynecology
OBS	Obstetrics
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OS	Other
OT	Otology
OTO	Otolaryngology
P	Psychiatry
PD	Pediatrics
PDA	Pediatric Allergy
PDC	Pediatric Cardiology
PDE	Pediatric Endocrinology
PDR	Pediatric Radiology
PDS	Pediatric Surgery
PH	Public Health
PHO	Pediatric Hematology-Oncology
PM	Physical & Rehabilitation Medicine
PNP	Pediatric Nephrology
PS	Plastic Surgery
PTH	Pathology
PUD	Pulmonary Disease
PYA	Psychoanalysis
PYM	Psychosomatic Medicine
R	Radiology
REN	Reproductive Endocrinology
RHI	Rhinology
RHU	Rheumatology
RIP	Radioisotopic Pathology
RO	Radiation Oncology
TR	Therapeutic Radiology
TRS	Traumatic Surgery
TS	Thoracic Surgery
U	Urology
US	Unspecified
VS	Vascular Surgery

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Bailiff, Robert	082	Springfield
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Batan-Co, Ruby L.	190	Chesterfield
Baudendistel, Lawrence J.	190	St. Louis
Behbahani, Parviz M.	190	Bridgeton
Bell, Stephen	190	St. Louis
Bernard, Lisa	125	Kansas City
Bessonny, Eric J.	190	Naperville, IL
Bluestone, Kenneth I.	125	St. Louis
Blum, Carol A.	002	Excelsior Springs
Blum, Philip C.	125	Kansas City
Bode, Eugene T.	125	Kansas City
Booth, Randall K.	214	Nevada
Borup, Jerrell L.	082	Springfield
Bowenschulte, Bradley A.	082	Springfield
Bowser, Robert L.	050	Independence
Bredemann, Jeffrey A.	125	Kansas City
Brian, William J.	082	Springfield
Brigden, Robert B.	102	Neosho
Brown, Freeman F., III	190	Ballwin
Brown, Norbert W.	125	KansasCity
Bucol, Kevin D.	190	St. Louis
Bult, Mark J.	082	Nixa
Butterfield, Mari Anne	125	Lee's Summit
Casement, Brian A.	125	Kansas City
Chang, Chil K.	026	Columbia
Charapata, Steven G.	125	Kansas City
Chien, David W.	190	Maryland Heights
Clemens, Robert M.	178	Sedalia
Cobb, Milton L.	190	St. Louis
Cohen, Harry B.	014	Mexico
Cohn, Steven G.	125	Kansas City
Cole, Donald E.	066	Springfield
Coleman, Kevin A.	190	St. Louis
Cook, James R.	082	Springfield
***Corzine, John J.**	030	St. Joseph
Couper, Nicholas B.	026	Columbia
Creighton, Christopher P.	002	Morgantown, WV
Criscione, James S.	190	St. Louis
Crumpacker, Rex K.	102	Joplin
Cunningham, Milamari A.	026	Columbia
Daily, James M.	082	Springfield
***Daniels, William B.**	125	Kansas City
Danner, Shavonne L.	125	Leawood, KS
***Davis, Larry E.**	050	N. Kansas City
***Delaney, Adrain J., Jr.**	125	Kansas City
DeBoard, James W.	190	St. Louis
***DeLucia, Joseph A.**	206	West Plains
Doerhoff, Adelia L.	058	Jefferson City
Dolan, Patrick H.	190	St. Louis
Duckett, William D.	135	Rolla
Edelman, Kent J.	102	Joplin
Eggers, George W., Jr.	026	Columbia
Ellis, S. Christopher	125	Independence
Faszholz, Mark S.	190	Chesterfield
Ferrari, Herbert A.	190	St. Louis
Fibuch, Eugene E.	125	Kansas City
***Fisher, Robert B.**	026	Columbia
Flores, Jhonson E.	190	Chesterfield
Fogel, Steven T.	190	Chesterfield
Foote, Daniel D.	082	Springfield
Forand, Joseph M.	190	St. Louis
Forstot, Robert M.	190	St. Louis
***Frederick, Mark R.**	058	Jefferson City
Friedman, Michael J.	026	Columbia
Friedrich, Anthony P.	190	St. Charles
Friend, T. Gregory	125	Kansas City
Fromme, Glenn A.	082	Springfield
Fryer, Dorothy S.	190	St. Louis
Gahn, Richard S.	002	St. Louis
Gholkar, Vijay R.	125	Kansas City
Gibbons, James J.	190	St. Louis
***Gibbons, Jerry L.**	190	St. Louis
Gibbons, Robert T., Jr.	125	Overland Park, KS
Gibson, William P.	190	Chesterfield
Gilliland, Craig	002	Kansas City
Glenski, James A.	125	Kansas City
Gordon, Bruce J.	026	Columbia
Granberg, Steven J.	190	St. Louis
***Greer, Sam T.**	102	Joplin
Griffin, Donald R.	002	Kansas City
Grubb, Michael M.	102	Joplin
Gunderson, Jeffrey K.	082	Springfield
Gupta, Nilakshi	026	Columbia
Gurba, Carol L.	125	Kansas City
Guy, Cynthia S.	190	St. Louis
Hagen, Douglas W.	125	Kansas City
Hari, Magaral S.	102	Joplin
Hata, Tara M.	026	Columbia
Hecht, Brian S.	026	Columbia
Heise, Julie R.	125	Liberty
Herdoiza, Alfonso W.	125	Shawnee Mission, KS
Herold, Robert E.	189	St. Charles
Hervey, William H.	125	Kansas City
Hill, Michael L.	102	Joplin
Hoech, George P., Jr.	125	Kansas City
Hoehner, Paul J.	030	St. Joseph
Holloway, Robert B.	190	St. Louis
Holtmann, Barbel	190	St. Louis
Hubbard, John D.	125	Kansas City
Hudson, Randall B.	125	Kansas City
Huff, Kalaichelvi R.	102	Joplin
***Hull, Jeffrey F.**	125	Kansas City
Hull, Timothy A.	125	Kansas City
Iwane, Akira	190	Chesterfield
Jaax, Jeffrey D.	125	Kansas City
Janeczko, Gregory F.	082	Springfield
Jenkins, James J.	190	St. Louis
Johnson, Garry A.	190	DesPeres
Jones, Dwayne E.	125	Shawnee, KS

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*Doctor of Osteopathy

Jones, Gale O.	Kansas City	125
Jones, Robin R.	Columbia	026
Jorgensen, Eric D.	Columbia	026
Joshi, Surekha K.	St. Louis	190
Kappesser, Roland C.	St. Louis	190
Keller, Barbara P.	Columbia	026
Kelly, James B.	Kansas City	125
Kelly, Joseph G.	N. Kansas City	050
Kenney, John D., III	Kansas City	125
***Kesseler, Randall G.**	Springfield	082
Khoury, Cecile S.	Leawood, KS	125
Kimble, Harvey S.	Kansas City	125
King, James A.	Des Peres	002
Kiyanclar, M. Emin	St. Louis	190
Knop, Kevin F.	Liberty	002
Kohm, Mary Jane F.	St. Louis	002
Krug, Paul E.	Kansas City	125
Kulkarni, Nandini S.	St. Louis	190
Kussman, Mary E.	St. Louis	002
Lampert, Benjamin A.	Springfield	082
Landrum, Alice L.	Columbia	026
Laposky, Lynda L.	Chesterfield	190
Latour, Jonathan G.	Columbia	026
Laughlin, Thomas P.	Kansas City	125
Lawson, Noel W.	Columbia	026
Lee, Leander K.	St. Louis	190
Lerner, Bruce	Independence	125
***Logston, David G.**	Springfield	082
Lonergan, James H.	Kansas City	125
***Lucio, John C.**	Jefferson City	058
Ludwikosky, Mike A.	Leawood, KS	125
Lytle, Michael F.	Shawnee Mission, KS	125
Macler, Henry H., Jr.	Hazelwood	190
Maddipati, Sreedevi	St. Louis	190
Mallow, James E.	Kansas City	125
Martin, Patricia A.	Kansas City	125
Matson, Jeffrey A.	Kansas City	125
Matthews, J. Mark	Kansas City	125
Mayuga, Edgardo G.	St. Louis	190
McCord, E. Scott	Columbia	026
McCray, Stephen A.	N. Kansas City	050
McDonald, Michael G.	Joplin	102
McIntosh, Donald E.	Kansas City	125
McNitt, Jay D.	Kansas City	125
Meridy, Howard W.	Joplin	102
Mestad, Peter H.	Kansas City	125
Meyer, D. Joseph, Jr.	Columbia	026
***Michael, Roy A.**	Jefferson City	058
Miller, Robert N.	St. Louis	190
Moore, Richard E.	Cape Girardeau	042
***Morley, Ronald F.**	Jefferson City	058
Morrison, Robert R.	Kansas City	050
Nelson, Richard E.	Kansas City	125
***Neuenswander, Keith W.**	Kansas City	050
Nielsen, Carl H.	St. Louis	190
Nordhues, Craig A.	Springfield	082
Nye, Robert A.	St. Louis	002
Oakley, Margaret M.	St. Louis	190
Opper, Susan E.	Kansas City	125
Orr, Robert M.	Kansas City	125
Owens, William D.	St. Louis	190
Parker, Craig A.	Kansas City	125
Parker, Kim E.	Kansas City	125
Parks, Jon C.	Poplar Bluff	034
Patel, Bipin T.	St. Joseph	030
Pavelonis, Joel D.	Kansas City	002
Perryman, Kathy M.	Kansas City	125
Petersen, Larry D.	Springfield	082
Piontek, James F.	Liberty	050
Politi, Gregory B.	Kansas City	125
Porter, Michael J.	Kansas City	125
Porter, Susan S.	Kansas City	125
Potts, Fred E., III	Laredo, TX	082
Pryor, Ira Joe	Joplin	102
Rao, Vijaya Kumar P.	Joplin	102
***Ray, Terry L.**	Columbia	026
Reaney, John A.	Kansas City	125
***Rhoads, Mark D.**	Joplin	102
***Ripperger, Kevin L.**	Springfield	082
Robertson, Terence A.	Leawood, KS	125
Rodrigo, Bernardo R.	St. Louis	190
Romkema, George E.	St. Louis	190
Roth, Alfred D.	Mission, KS	125
Rumpf, Ronald P.	Columbia	026
***Russell, Robert B.**	Cape Girardeau	042
Schane, Catherine L.	Springfield	082
Schneider, J. Michael	Springfield	082
Schnurr, Thomas C.	Jefferson City	058
Schuessler, Edward C.	St. Albans	190
Shelley, William C.	Kansas City	125
***Shipman, Wade M.**	Rogersville	082
Shopper, Glenn K.	Kansas City	125
Smith, Sally L.	Chesterfield	190
***Smith, Toni R.**	Kirksville	148
Smith, Victorija L.	Springfield	082
Southwick, Christopher L.	Columbia	026
Spade, Diana J.	Springfield	082
Stark, William H.	Kansas City	125
***Steele, Brian K.**	Joplin	102
Stewart, Angela R.	Columbia	026
Stiles, Michella M.	Kansas City	125
Stoops, Stephen L.	Kansas City	125
Stromberg, Eric D.	Kansas City	125
***Suthoff, Jim**	Joplin	102
Sutton, Trevor S.	St. Louis	002
***Tanner, Scott W.**	Jefferson City	058
Tate, Kara L.	Kansas City	125
Tatini, Paparao	St. Louis	002
***Tewis, Huey D.**	Cape Girardeau	042
Thomas, James J.	Kansas City	125
Thompson, David E.	Lee's Summit	125
Thompson, Paul H.	Branson	208
Tiojanco, Milagros E.	Kansas City	125
Tompson, Richard G.	West Plains	206
Towle, Daniel J.	Kansas City	125
Triantafillou, Anastasios	St. Louis	190
Tuohy, Gerald F.	Kansas City	125
Tuohy, Stephen E.	Kansas City	125
Vallurupalli, Vijayalakshmi	Bridgeton	190
Venneman, Charles R.	Kansas City	125
***Vialle, Gene M.**	Kansas City	125
Villafuerte, Nila A.	St. Louis	190
Vogel, Arthur P.	Shawnee Mission, KS	125
Walker, Andrew	Leawood, KS	002
Waring, J. Michael	Kansas City	125
Watson, Timothy B.	Columbia	026
***Weaver, Bruce E.**	Columbia	026
Weaver, Mark E.	Springfield	082
***Webb, James J.**	Joplin	102
Wempe, Michael J.	St. Joseph	030
Westcott, Bruce R.	Cape Girardeau	042
Wilhite, Tria K.	Shelbyville	150
Wilkinson, Linda	Kansas City	125
Williams, C. Mark	Kansas City	125
Williams, Todd L.	Joplin	102
Wolff, Dolores P.	Chesterfield	190
***Wright, Michael D.**	St. Joseph	030
Wright, Robert W., III	Kansas City	125
Yates, Charles L.	Columbia	026
Yedlin, Jay H.	Kansas City	125
Young, Alexander H.	St. Louis	190
Young, Kenneth R.	Springfield	082
Young, Patricia A.	N. Kansas City	050
Youngblood, Frederick E.	Crystal City	106
Zukaitis, Mark G.	Kansas City	125

Cardiovascular Disease(CD)

Ahuja, Suraj P.	Kansas City	125
Akin, C. David	Independence	125
Apprill, Phillip G.	St. Louis	190

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Ashley, Lillard G., Jr.	Kansas City	125
Bai, Samuel S.	Festus	106
Banerjee, Dilip	Washington	074
Barr, W. Kent	N. Kansas City	125
Bateman, Timothy M.	Kansas City	125
Beauchamp, Gary D.	Shawnee Mission,KS	125
Biel, Stanley I.	Bridgeton	190
Billadello, Joseph J.	St. Louis	002
Bloom, Stephen A.	Overland Park, KS	125
Bogart, Douglas B.	N. Kansas City	125
Bresnahan, Dennis R.	Kansas City	125
Callicoat, Paul E., Jr.	Joplin	102
Chapman, James B.	Cape Girardeau	042
Chu, Paul R.	Independence	125
Chun, Duck Sung	St. Louis	190
Cochran, David S.	Springfield	082
Conn, Robert D.	Kansas City	125
Cooksey, Jon D.	St. Louis	190
Corcoran, Francis H.	Joplin	102
***Cox, John M.**	Joplin	102
Cupp, Gerald V.	Columbia	026
Davis, J. Lawrence	St. Louis	190
Davis, Richard C., Jr.	Columbia	026
Deane, Louis V., Jr.	St. Louis	190
Drozda, Joseph P., Jr.	Chesterfield	190
Dwyer, James G.	St. Louis	190
Earnest, James B.	Kansas City	125
Fagan, Leonard F., Jr.	St. Louis	190
Farrar, Michael W.	Merriam, KS	125
Freeman, James A.	Columbia	026
Gafford, Franklin H., IV	St. Louis	190
George, Achenklinju K.	West Plains	206
Gibson, Paul H.	St. Louis	190
Glueck, Robert M.	Kansas City	125
Godlewski, Krystof J.	Kansas City	125
Good, Thomas H.	Kansas City	125
Ha, Richard J.	Hannibal	150
Hamilton, William P.	St. Louis	190
Hammond, Billy A.F.	Cape Girardeau	042
***Handlin, Larry R.**	Mexico	014
Harshman, David M.	St. Louis	190
Hartzler, Geoffrey O.	Shawnee Mission, KS	125
Haycraft, Gordon L.	Cape Girardeau	042
Hegde, S. Roy	Kansas City	125
Henry, Clarke L., Jr.	Kansas City	125
Herman, Robert L.	Kansas City	125
Hess, John P.	St. Louis	190
Hills, Joe E.	Springfield	082
Hindupur, Mohan R.	St. Joseph	030
Huber, Kenneth C.	Kansas City	125
Hubert, John W.	Bridgeton	190
Jackson, Jay A.	Kansas City	125
Jain, Savitri G.	St. Louis	190
Johnson, Warren L., Jr.	Kansas City	125
Kennett, Jerry D.	Columbia	026
Kilgore, John W.	St. Louis	190
Kindred, Lynn H.	Kansas City	125
Kistler, W. David, Jr.	St. Louis	190
Kroetz, Frank W.	Sikeston	202
Laughlin, Edward J.	Independence	125
LaFoe, William K.	Cape Girardeau	042
Lee, Gerald B.	Kansas City	214
Lee, Jung H.	Crystal City	106
Levi, Bernard	Overland Park, KS	125
Long, John W.	Columbia	026
Love, Gerry A.	Liberty	125
McCallister, Ben D.	Kansas City	125
McConahay, David R.	Shawnee Mission, KS	125
Meyer, Randall E.	Jefferson City	058
Miller, John T.	N. Kansas City	125
Mizell, Myron W.	Springfield	082
Montgomery, Michael A.	N. Kansas City	125
Moore, Thomas B.	Joplin	102
Morello, Patrick J.	Jefferson City	058
Mukharji, Jhulan	Kansas City	125
Musick, William D.	Jefferson City	026
Nordlicht, Scott M.	St. Louis	190
Oliver, G. Charles	St. Louis	002
Penilla, Antonio R.	St. Louis	190
Politte, Lenard L.	Columbia	026
Porter, Charles B.	Kansas City	125
Riner, Ronald N.	St. Louis	190
Roselman, Michael J.	Springfield	082
Rutherford, Barry D.	Kansas City	002
Ruwitch, Joseph F., Jr.	St. Louis	190
Sanders, Jack S.	Jefferson City	058
Scharf, Daniel	Overland Park, KS	125
Shimshak, Thomas M.	Kansas City	125
Spadaro, James J.	St. Louis	190
Spitler, Allen L.	Cape Girardeau	042
Spurny, Otto M.	Kansas City	125
Stahl, Lloyd D.	Overland Park, KS	125
Steinhaus, David M.	Kansas City	125
Stickley, Louis P.	St. Louis	190
Stuppy, Robert J.	Joplin	102
Sweeney, Michael J.	Kansas City	125
Talbert, Clifford R.	Cape Girardeau	042
Tritz, James F.	Jefferson City	058
Valuck, Richard P., Jr.	Hannibal	150
Weiss, Alan N.	St. Louis	190
Whiting, Richard B.	St. Louis	190
Wolff, Gerald A.	St. Louis	190

Cardiovascular Surgery(CDS)

Bailey, Colin E.	Columbia	026
Borkon, A. Michael	Kansas City	125
Bryant, Lester R.	Columbia	026
Crouch, John A.	Columbia	026
Curtis, Jack J.	Columbia	026
Demmy, Todd L.	Columbia	026
Ewy, Marvin F.	Columbia	026
Foley, Jonathon K.	Cape Girardeau	042
Freund, William L.	N. Kansas City	125
Habib, Ahmed A.	Columbia	026
Hannah, Hamner, III	Prairie Village, KS	125
Hiremath, Yoganand J.	Joplin	102
Johnson, Fritz M.	Springfield	082
Kase, James B., Jr.	N. Kansas City	125
Lammoglia, Francisco J.	St. Joseph	030
Laster, Steven B.	Kansas City	125
Lawhorn, Stephanie L.	Shawnee Mission, KS	125
Magalski, Anthony	Kansas City	125
Mangalat, Narayanan K.	Joplin	102
McCroskey, Brian L.	Kansas City	125
Morrison, Stephen K.	Springfield	082
Ogle, William R.M.	Cape Girardeau	042
Pinckley, James N.	Springfield	082
Reinsvold, Thomas M.	Joplin	102
Retter, Kenneth W.	Cape Girardeau	042
Rigden, L. Brick	N. Kansas City	125
Rogers, James D.	Springfield	082
Ruff, Paul G.	Springfield	082
Schmaltz, Richard A.	Columbia	026
Schneider, Alan M.	Overland Park, KS	125
See, W. Mike	Columbia	026
Stamatis, John J.	Springfield	082
Starr, Steven K.	N. Kansas City	125
Voelker, Donald J.	Columbia	026
Walls, Joseph T.	Columbia	026

Child Neurology (CHN)

Dodge, Philip R.	St. Louis	190
Mantovani, John F.	St. Louis	190
Prensky, Arthur L.	St. Louis	190

*Doctor of Osteopathy

Child Psychiatry (CHP)

Alfie, Salomon	125	Shawnee Mission, KS
Birchansky, Bonnie-Lee	030	St. Joseph
Bogard, Phyllis J.	030	St. Joseph
Daniel, A.E.	026	Columbia
Edwards, James E.	190	St. Louis
Huk, Stephen G.	050	Overland Park, KS
Lorenzo, Edilberto B.	125	Poplar Bluff
McCallum, Kimberli E.	190	Chesterfield
Quiason, Emmeline P.	125	Independence
Shearer, Robert D.	058	Jefferson City
Sumer, Emel A.	190	Bridgeton

Clinical Pathology (CLP)

Bell, Gordon A.	125	Overland Park, KS
Druet, Robert L.	082	Springfield
Haake, Gregory K.	082	Springfield
Nomura, Roy M.	190	St. Louis
Posey, Douglas H., Jr.	030	St. Joseph
Raborar, Arteso C.	082	Springfield
Thal, Sanford M.	190	St. Louis

Colon & Rectal Surgery (CRS)

Brabbee, Gregory W.	190	St. Louis
Cirocco, William C.	125	Shawnee Mission, KS
Fleshman, James W.	190	St. Louis
Gose, Don F.	082	Springfield
Graham, Bruce D.	125	Shawnee Mission, KS
Kodner, Ira J.	190	St. Louis
Robbins, Philip L.	190	St. Louis

Critical Care Medicine (CCM)

Hata, J. Steven	026	Columbia

Dermatology (D)

Ailor, Susan K.	026	Columbia
Albert, I. Renee	190	St. Louis
Anderson, Daphne W.	082	Springfield
Anderson, Frank K.	189	St. Charles
Anderson, Philip C.	026	Columbia
Aronberg, Jerome M.	190	St. Louis
Ashby, Jennifer D.	125	N. Kansas City
Bauschard, Frederick D.	190	St. Louis
Chanasue, John A.	190	Florissant
Creech, Fred T.	026	Cape Coral, FL
Dempsey, Kenneth J.	202	Sikeston
DeSpain, John D.	026	Columbia
Dilworth, Jacquelyn B.	190	St. Louis
Dyer, Gary A.	030	St. Joseph
Eisen, Arthur Z.	190	St. Louis
Foote, Jerry E.	026	Columbia
Forsman, Karen E.	190	St. Louis
Gentry, Michael A.	082	Springfield
Glaser, Dee Anna	002	St. Louis
Griffin, Darrell L.	138	Farmington
Gunn, Victoria	058	Jefferson City
Gunnoe, Robert E.	125	Kansas City
Hall, John C.	125	Kansas City
Higgins, Ronald A.	125	Kansas City
Hilton, Paul E.	102	Joplin
Hironimus, John E.	190	St. Louis
Hruza, George J.	190	St. Louis
Hruza, Luciann L.	002	St. Louis
Johnson, Dallas A.	125	Overland Park, KS
Kunin, Audrey Gottlieb	002	Kansas City
Lane, Daniel K.	190	St. Louis
Levenson, Ina	034	Poplar Bluff
Lynch, Thomas W.	082	Springfield
Major, Troy E.	082	Springfield
Marrs, David B.	189	St. Charles
Matlock, Mark S.	102	Joplin
McCadden, Michael E.	190	St. Louis
Medler, P. Louis	190	St. Louis
Melia, B.J., Jr.	125	Kansas City
Miller, Charles W.	190	St. Louis
Morrow, N. Eugene	082	Springfield
Oleson, Gale B.	125	Blue Springs
Palmer, Stephen M.	190	St. Louis
Payne, David E.	026	Columbia
Portnoff, Lee S.	190	St. Louis
Powell, John A.	190	St. Louis
Reese, Lester T.	190	St. Louis
Ring, Lisa B.	190	Bridgeton
Roller, James A.	026	Columbia
Scott, Jamie A.	082	Springfield
Simmons, Jess S.	102	Joplin
Stoecker, William V.	135	Rolla
Stover, Paul M.	125	Overland Park, KS
Swinfard, Ronald W.	026	Columbia
Thomas, F. Anthony	050	Kansas City
Tiefenbrunn, Sharon F.	190	St. Louis
Tucker, Dolores R.	190	Chesterfield
Uhlemann, John H.	189	St. Charles
Vitale, Stephen J.	190	Chesterfield
Walsh, Richard J.	030	St. Joseph
Werth, Joseph A.	058	Jefferson City
Wolfe, Edward M.	190	St. Louis
Zanol, Karen E.	026	Columbia
Zurowski, Susan M.	026	Columbia

Diagnostic Radiology (DR)

Amini, Jafar	125	Shawnee Mission, KS
Anderson, David R.	042	Cape Girardeau
Anthony, James P.	125	Kansas City
Applewhite, Thomas A.	190	St. Louis
Balfe, Dennis M.	190	St. Louis
Barton, Premsri T.	190	St. Louis
Beal, Catherine E.	190	St. Louis
Belshe, Sidney B.	058	Jefferson City
Boodram, Mitra B.	190	St. Louis
Brent, Lanny R.	082	Springfield
Brown, Mike J.	042	Cape Girardeau
Carlton, Lynn N.	082	Springfield
Churchill, Robert J.	026	Columbia
Cooper, Barry R.	050	N. Kansas City
Cram, John W.	082	Springfield
Crepps, Louis F.	190	St. Louis
Cronemeyer, Richard L.	125	Lee's Summit
Cusumano, Joseph V.	190	St. Louis
Cyriac, George K.	014	Mexico
Davis, Gene L.	190	Chesterfield
Dell, Robert V.	150	Hannibal
Dever, Robert L.	102	Joplin
Devkota, Jagadishwar	026	Columbia
Dierberg, Dale F.	074	Chesterfield
Engels, John T.	190	St. Louis
Ernst, Edwin C., III	190	St. Louis
Evens, Ronald G.	190	St. Louis
Fisher, James K.	125	Shawnee Mission, KS
Fletcher, Dale M.	190	St. Louis
Foss, Jonathan M.	190	St. Louis
Francis, Roger A.	120	Linn Creek
Gafarian, Kathleen	082	Springfield
Garvin, Charles F.	190	St. Louis
Gehm, Louis E.	214	Butler
Geisse, Guillermo C.	190	St. Louis
Gennaoui, Jad M.	190	St. Louis
Gibson, Merlyn D.	026	Columbia
Glazer, Harvey S.	190	St. Louis

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Goodhope, Karen F.	190	St. Louis
Graviss, E. Richard	190	St. Louis
Greditzer, Harry G., III	190	St. Louis
Gresick, Robert J., Jr.	190	St. Louis
Hardy, Jeffery A.	190	St. Louis
Hazuka, David F.	125	Shawnee Mission, KS
Hedgepeth, Bruce L.	082	Springfield
Hillard, Alan E.	026	Columbia
Hinson, Gary W.	125	Overland Park, KS
Hoffman, Mark J.	190	St. Louis
Holloman, Walter G.	190	Ballwin
Horner, Charles W.	125	Kansas City
Idstrom, Mark E.	125	Kansas City
Jones, Maynard C., Jr.	125	Lee's Summit
Jones, Paul S.	102	Joplin
Junker, James A.	106	St. Louis
Keller, Stephen M.	190	St. Louis
Koontz, Kenneth L.	125	Kansas City
Krahn, Michael J.	050	Kansas City
Kuckelman, Richard G.	125	Kansas City
Lee, H.T.	026	Columbia
Levine, Richard S.	190	St. Louis
Levitt, Robert G.	190	St. Louis
Martin, David S.	190	Chesterfield
Mayes, Ben R.	190	St. Louis
McManus, Gerald	050	N. Kansas City
Merkle, John A.	190	St. Louis
Moore, Michael T.	214	Nevada
Morgan, John L.	082	Springfield
Nelson, David E.	082	Springfield
O'Toole, Patrick M.	125	Kansas City
Olson, Robert J.	082	Joplin
Omell, Gary H.	190	St. Louis
Pohl, David L.	190	St. Louis
Pottenger, L. Kenneth	102	Joplin
Price, Hilton I.	190	St. Louis
***Radinsky, Stephen**	190	St. Louis
Rosenthal, Debra D.	190	St. Louis
Sadhu, Vijay K.	026	Columbia
Sanders, Harold L.	026	Gravois Mills
Scearce, Robert L.	058	Jefferson City
Scheible, Robert F.	190	St. Louis
Schwegler, Robert G.	125	Shawnee Mission, KS
Seelig, Robert D.	002	St. Louis
Shaplin, Alfred D.	106	Ballwin
Smith, Emily L.	190	St. Louis
Sobky, George H.	190	Louisiana
Soha, Joseph J., Jr.	026	Columbia
Stevens, Edward M.	030	St. Joseph
Stewart, James G.	190	St. Louis
Stoecker, Willeford J.	042	Cape Girardeau
Stolar, Cary G.	190	St. Louis
Sullivan, Dan T.	082	Springfield
Sullivan, David M.	082	Springfield
Sullivan, John A.	082	Springfield
Swaney, Charles M.	026	Columbia
Sweeney, Thomas P.	082	Springfield
Szoko, Edward	190	St. Louis
Thalblum, Harvey	125	Kansas City
Thomasson, Jeffrey L.	190	St. Louis
Tobler, Jerry	190	Chesterfield
Totty, William G.	190	St. Louis
Trotta, Philip C.	190	St. Louis
Vannier, Michael W.	190	Iowa City, IA
Vas, Wenzel G.	190	St. Louis
Weis, Ronald R.	125	Kansas City
Wiele, Kimberly N.	190	St. Louis
Wilcox, Dennis M.	125	Leawood, KS
Wilson, J. Mark	082	Springfield
Wolski, James R.	082	Springfield

Emergency Medicine (EM)

Adkins, Charlene	026	Columbia
Ammala, Edward D.	135	Rolla
***Barrow, Chelmer L., Jr.**	190	Lake St. Louis
Bell, Malinda H.	125	Shawnee Mission, KS
Berry, Danny T.	042	Cape Girardeau
Blaine, James R.	082	Springfield
Bonney, Saml C.	074	Washington
Carter, Gary L.	050	N. Kansas City
Collins, Samuel B.	026	Columbia
Criscione, James R., Jr.	190	St. Louis
DeCoursey, Kenneth A.	042	Cape Girardeau
***Draper, Richard E.**	042	Cape Girardeau
Dunlap, Michael D.	030	St. Joseph
DuMontier, Alan J.	190	Chesterfield
Ferguson, Edward W.	190	St. Louis
Gambill, Gary L.	190	Chesterfield
Grandstaff, P. Matthew	125	Prairie Village, KS
Grisham, Thomas D.	074	Washington
Hassen, Mark A.	002	St. Louis
Hicks, Robb R., IV	042	Cape Girardeau
Hierholzer, Rebecca S.	125	N. Kansas City
Judge, Steven J.	074	Washington
Julien, Rene L.	190	Belleville, IL
***Karr, Jerry L.**	042	Cape Girardeau
Keesal, Dennis	189	St. Charles
Kensel, Robert S.	082	Rogersville
Kolda, Michael A.	042	Cape Girardeau
Labayen, Ricardo A.	125	Overland Park, KS
***Landers, Gary A.**	050	N. Kansas City
Lewis, Lawrence M.	190	St. Louis
Lewis, William S.	042	Cape Girardeau
Lombardo, Richard J.	125	Belton
Lorei, John M.	002	Kansas City
McEnroe, John D., Jr.	125	Kansas City
McIntosh, Douglas A.	042	Cape Girardeau
McMurry, Ted A.	082	Springfield
***Mitchell, Richard N.**	042	Cape Girardeau
Moranville, Benedict A.	030	St. Joseph
Morgan, Edward B.	190	St. Louis
Nelson, Michael J.	125	Lee's Summit
Pancoast, Charles H.	042	Cape Girardeau
Parks, William C.	026	Columbia
Patel, Raman J.	030	St. Joseph
Peimann, Nathan P.	215	St. Louis
Poggemeier, David A.	189	St. Charles
Prickett, David C., Jr.	050	Kearney
Psaltis, Philip E.	030	St. Joseph
***Ramsey, Jesse R.**	042	Cape Girardeau
Randolph, Gary	102	Joplin
Ratcliff, Keith M.	074	Washington
Ricci, Walter J.	125	Overland Park, KS
Riscoe, James M.	102	Joplin
***Roberts, Rebecca L.**	030	Kansas City
Rush, Marvin R.	174	Ste. Genevieve
Russell, Steven L.	050	Kansas City
Scarborough, Betty F.	125	Shawnee Mission, KS
Scarborough, Mark R.	125	Kansas City
***Schnur, David**	042	Cape Girardeau
Selove, Peter T.	102	Joplin
Skeins, Edward J., Jr.	082	Springfield
Smith, Earl E., III	190	St. Louis
Smith, Norman A.	026	Columbia
Steele, Mark T.	002	Kansas City
Stoliar, John B.	190	St. Louis
Sullivan, Christine	125	Overland Park, KS
Svancarek, William P.	190	St. Louis
Szewczyk, Michael J.	026	Columbia
Toy, Karen L.	178	Sedalia
***Turner, Timothy T.**	002	Barrington, IL
Vaughan, Mark	215	Kansas City
Velander, Robert D.	125	Blue Springs
Waeckerle, Joseph F.	125	Leawood, KS
Weaver, Michael L.	125	Kansas City
Weber-Bornstein, Nancy	042	Cape Girardeau

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Endocrinology (END)

Duda, Ralph J., Jr.	Springfield	082
Duick, Daniel S.	Cape Girardeau	042
Hamburg, Mitchell S.	Kansas City	125
Hellman, Richard	N. Kansas City	125
Henson, Bruce E.	Kansas City	125
James, Ronald C.	Columbia	026
Koppers, Lawrence E.	Springfield	082
Porte, Karen L.	Joplin	102
Quick, William W.	Kansas City	125
Rosen, Howard M.	N. Kansas City	125

Facial Plastic Surgery (FPS)

Buchwach, Kenneth A.	Independence	125
deLeeuw, Karel A.	Springfield	082
LaFerriere, Keith A.	Springfield	082
Prstojevich, Steven J.	Kansas City	125
Simo, Frank	St. Louis	190
Tanner, John P.	Kansas City	125
Thomas, J. Regan	St. Louis	190

Family Practice (FP)

Abu Dalu, Ziad	St. Louis	190
Adams, Stephen R.	Springfield	082
***Adkison, Brian W.**	Seymour	082
Ahnemann, Janet L.	Clinton	086
Allan, James E.	Jefferson City	058
Allcorn, Donald K.	Lincoln	178
Anglo, Luis B.	St. Louis	190
***Asher, Kennett D.**	Jackson	042
Askew, John H.	Sikeston	202
Auner, J. David	Ironton	138
Baker, Carl N.	St. Louis	190
Baker, Donald L.	Union	074
Barbe, David O.	Mountain Grove	206
Batty, Thomas V.	Eldorado Springs	214
Belden, Jeffery L.	Columbia	026
Bellamy, Bruce G.	Clinton	086
Benedict, Holly J.	Ozark	082
Bennett, John E.	Jefferson City	058
Berner, Carol T.	Springfield	082
Bernhardt, Gary D.	Overland Park, KS	125
***Betz, William T.**	Grandview	125
***Bieser, R. Dan**	Cape Girardeau	042
Binz, Donald E.	St. Peters	189
Birkby, William F.	Columbia	026
Boatright, Kevin	Farmington	138
***Bohn, Sara A.**	California	058
Bollier, Rene P.	Kansas City	125
Bowles, Richard P.	Liberty	050
Brockhaus, Jayne R.	Warrensburg	110
Brown, Merlin D.	St. Joseph	030
Brunworth, David	Washington	074
Bryant, William A.	Sikeston	202
Buffaloe, Robert N.	Jefferson City	058
Buie, Steven E.	Kansas City	125
***Bynum, Robert L.**	Ashland	026
Byrum, Fritz A.	Ballwin	190
Cady, Roger K.	Springfield	082
Caldwell, Fred	Poplar Bluff	034
Campbell, Albert J.	Sedalia	178
Campbell, David C.	St. Louis	190
Carey, Larry J.	Springfield	082
Carney, Stephen E.	Sikeston	202
Carr, George W.	Jefferson City	058
Carranza, Mauro J.	St. Louis	190
Carter, James E., Jr.	Leawood, KS	125
Caster, Philip W.	Lebanon	115
Catron, David O.	Cape Girardeau	042
Chaffin, Jerald D.	Branson	208
Chambon, Gregory E.	Kansas City	125
***Chandra, Ram**	Higginsville	118
Chavez, Salvador	St. Louis	190
Clark, David B.	Springfield	215
Cogley, Patrick J.	Nixa	208
Collison, R. Michael	Springfield	082
Colwill, Jack M.	Columbia	026
Comfort, George D.	Mexico	014
Covert, Richard A.	St. Louis	190
Cravens, William P.	Fulton	038
Crosnoe, Janna R.	Cape Girardeau	042
Dahlberg, Thomas E.	Springfield	082
Dang, Robert C.	Pleasant Hill	214
Davis, Carl S.	Lee's Summit	125
Dean, Walter E.	Maryville	158
***Dekker, Anthony H.**	Kansas City	125
Dempsey, Herbert A.	Lee's Summit	125
***Dempsey, Herbert E.**	Lee's Summit	125
Derrington, Kenneth L.	Laurie	120
Devabhaktuni, Rama Devi	Chesterfield	190
DeLine, Jim	Macon	046
Dickerson, Malcolm J.	Eldon	058
Dierker, Harry D.	Columbia	026
Dimayuga, Nestor G.	Mansfield	206
Dixon, Druery J.	West Plains	206
Dodson, Jack M.	Jefferson City	058
Domke, Henry F.	New Bloomfield	058
Donnell, Harold E.	DeSoto	106
Donnell, William S., Jr.	Bolivar	066
Dorsch, Stephen E.	Independence	125
Dougherty, Thomas M., Jr.	Gladstone	054
Downey, Jon P.	Cape Girardeau	042
***Dunn, Roxanne M.**	St. Joseph	030
Dunshee, Robert E.	Maryville	158
Dyer, Curtis W.	Warrensburg	110
Ekern, H. Peter	Mexico	014
Elcock, Devera M.	St. Louis	190
***Eldenburg, Steven C.**	Sedalia	178
***Elder, Mark J.**	Springfield	082
Elfrink, Melanie Eden	Marshall	198
Elliott, Wendell H.	Poplar Bluff	034
Fakhoury, Donald A.	Kansas City	050
Florence, Kerry E.	Washington	074
Fowler, Marvin L.	West Plains	206
Franey, Michelle R.	Kansas City	125
Frederickson, Robert L.	Sedalia	178
Freeland, Arthur G.	Warrensburg	110
***Fry, John M.**	Ozark	082
Galbraith, Polly M.	Kansas City	125
George, Robert W.	Cape Girardeau	042
Giessel, Barton	Columbia	215
Gilbirds, William M., II	Kansas City	050
Glover, David	Warrensburg	110
Goff, John E.	Joplin	102
Good, Michael W.	Springfield	082
Green, William R.	St. Louis	190
Greenlund, Nelson C.	Nevada	214
Griffith, S. kent	Cape Girardeau	042
Groce, George D.	Fulton	038
Hall, Terry E.	Bethany	078
Halverson, Larry W.	Springfield	082
Hamid, Rashid S.	Marshall	198
Hardy, Stanton L.	Desloge	138
***Hare, Thomas**	Springfield	082
Harr, Patrick B.	Maryville	158
Harris, Louis B.	Bolivar	066
Haulard, Marcel E.	Wright City	190
Hayden, Melvin R.	Camdenton	120
Hayes, Lawrence L.	Kansas City	050
Hayes, Nancy J.	Mountain Grove	206
Hedrick, Frances A.	Holts Summit	058
Hernandez, J. Humberto	Gerald	074
Herrmann, Deborah A.	Marshall	198
Heutel, Lee B.	St. Louis	190

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Hite, Dennis E.	Lebanon	115
Hoffmann, Alan L.	Kansas City	125
Hofmeister, Roger W.	Columbia	026
Holley, Donald B.	Springfield	082
Holzem, Craig S.	Washington	074
Horton, John H.	Leawood, KS	125
Howell, David T.	Florissant	002
Hrabik, Brent	Tarkio	158
Hubbard, Sally L.	Springfield	082
Huffman, Larry	Branson West	208
Huguenard, Joseph R.	St. Louis	190
Humphrey, James D.	Mound City	158
Hunter, James K., Jr.	Fairfax	158
Huss, Randall D.	Rolla	135
Icaza, Ramiro	Jackson	042
Inocentes, Fe A.	O'Fallon	189
***Isaacs, Victor E.**	Scott City	042
Jackson, Max G.	Kansas City	125
Jenkins, Edward R.	Waynesville	135
Johnson, Lent C.	Hannibal	150
Johnson, Patrick E.	Farmington	138
Jones, Gordon	Sikeston	202
Jones, Justin E.	Mexico	014
Kairuz, Bartolome C.	St. Louis	190
Kanne, Marty A.	Kansas City	050
Kapp, Dave	Perryville	174
Kappesser, Netajean G.	St. Louis	190
Kasten, Mark C.	Cape Girardeau	042
Kelm, Shari L.	Ozark	215
Kenney, Douglas R.	Clinton	086
***Kessler, Alan Z.**	Kansas City	125
Kessler, William D., Jr.	Joplin	102
Kimlinger, William R.	Jefferson City	058
Klein, Kendel L.	Mt. Vernon	166
Koon, Ben H.	Bolivar	066
Kraemer, Edwin T.	Lee's Summit	125
Kruse, Carl R.	Palmyra	150
Laatsch, Robert H.	Poplar Bluff	034
Laiben, Gregg R.	Kansas City	125
Lauber, Joseph J.	St. Louis	190
Lavery, Daniel P.	Westphalia	058
***Law, Byron D.**	Kansas City	050
***Leahy, Cindy**	Holts Summit	058
Lee, Susan L.	Kansas City	125
Legler, Larry E.	Independence	125
Lepinski, Sandra L.	Kansas City	125
Leroux, Gene H.	Doniphan	034
Lisbon, Eleanor A.	Kansas City	125
Lischwe, Daniel H.	Bridgeton	190
Listerman, John C.	Lawrence, KS	030
Loeb, Mark	Columbia	026
Lofgreen, Craig S.	Kansas City	002
Long, Timothy P.	Marthasville	074
Lueckenhoff, Rebecca R.	Jefferson City	058
Luerding, Jeffrey A.	Kansas City	050
Lukavsky, James P.	Branson	208
Lutkewitte, Joseph F.	Ste. Genevieve	174
Lyle, Robert R.	Versailles	120
Madden, Michael L.	Kansas City	125
Markway, Gregory A.	Independence	125
Marshall, William G.	Glasgow	026
Martin, Mark W.	Lee's Summit	125
Martin, Robert A.	West Plains	206
Maska, Monte D.	Springfield	082
Mason, Mary Jane	Steelville	135
Masters, Edwin J.	Cape Girardeau	042
McDowell, James W.	Mexico	014
McFarland, Rodney J.	Neosho	166
McQuie, Ellen L.	Columbia	026
Mehaffy, Orville A.	Joplin	102
Mehr, David R.	Columbia	026
Meier, Francis X.	Jefferson City	058
***Melchior, David E.**	Perryville	174
Memken, John A.	Hannibal	150
Meyer, Jerry L.	Concordia	118
Miller, Kristin	Kansas City	215
Miller, William D.	St. Joseph	030
Molberg, Peter J.	Springfield	082
Montes, Arturo C.	Florissant	190
Morgan, W. Tom, Jr.	Columbia	026
Morton, Wayne L.	Osceola	214
Mueller, Randall E.	Columbia	026
Munger, Michael L.	Kansas City	125
Murphey, Nathaniel G.	Ashland	026
Myers, Carl M.	Platte City	125
Nadolski, Gary S.	St. Joseph	030
Newman-Koehn, Mica K.	Marshall	198
O'Connor, John J.	St. Louis	074
O'Rourke, James E.	Ste. Genevieve	174
Ojascastro, Alejandro C.	St. Louis	190
Oliver, Malcom B.	Republic	002
Ortiguero, Leopoldo M.	St. Louis	190
Ostergaard, Daniel J.	Kansas City	125
Ouellette, David F.	Hannibal	150
Palen, James E.	Cape Girardeau	042
Papreck, K.T.	Marshall	198
Paris, William H.	Bridgeton	190
Patterson, Donald R.	Joplin	102
Pennington, Michael S.	Springfield	166
***Perry, Christopher M.**	St. Louis	002
Philgreen, Donald E.	Kansas City	125
Phillips, Kenneth D.	Cape Girardeau	042
Phillips, Ronald L.	Kirksville	148
Piker, K. Dewayne	Springfield	082
Pimentel, Esperanza M.	St. Louis	190
Pinkham, Chris M.	Kansas City	050
Pitney, Phillip W.	Louisiana	150
Poggemeier, William H.	St. Charles	189
Pon, Marcelino	St. Louis	190
Potts, Donald A.	Kansas City	125
Presley, Jimmy C.	Springfield	082
Preston, Bruce E.	West Plains	206
Prica, George, Jr.	Columbia	026
Price, Richard C.	Harrisonville	214
Prince, Yvonne M.	Salem	135
Randolph, Bernard C.	St. Louis	190
Reeder, Charles C.	Smithville	050
***Reno, Lisa K.**	Lamar	018
Reust, Carin E.	Springfield	082
Reyes, Luis A.	Arnold	190
Reynolds, Susan K.	St. Louis	190
Rhee, Seoung E.	St. Louis	190
Richardson, George A.	Union	074
Roach, Mona S.I.	Prairie Village, KS	125
Robbins, Thomas D.	Jefferson City	058
Roberts, Theodore W.	Sikeston	202
Robertson, William D.	Poplar Bluff	034
Rogers, H. Bryan	St. Louis	190
Rosen, William K.	Springfield	082
Royce, Debra L.	Sarcoxie	102
Rues, Lawrence A.	Kansas City	125
Ryan, David	Trenton	078
Salanga, Percival B.	St. Louis	190
Scharrer, Alan J.	Holden	110
Schmitz, Ralph A.	Monett	166
***Schneider, Robert P.**	Memphis	150
Schutz, John P.	Excelsior Springs	050
Scott, E. David	Jefferson City	058
Scott, Hillard L.	St. Louis	190
Scott, Kenneth F.	Clinton	086
Sharp, Jeffrey A.	Sedalia	178
Shaw, James T.	Hermann	074
Shaw, Robert D.	Willow Springs	206
Sheahan, Peggy K.	St. Louis	215
Shields, Lawrence S.	Springfield	082
Shinn, Michael E.	Kansas City	050
***Sill, William**	St. Peters	189
Silvers, L. Michael	Kansas City	125

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Sincox, Charles H.	Washington	**074**
Sitzmann, Bryan L.	Kansas City	**050**
Slaughter, Larry	Columbia	**026**
Sleuwen, Leslie	St. Louis	**190**
Smith, Claude F.	Willow Springs	**206**
Smith, Gilbert D.	Poplar Bluff	**034**
Sparkman, Thomas C.	Cape Girardeau	**042**
Spence, Paul A.	Cape Girardeau	**042**
Spurlock, Luther D.	Rolla	**135**
Spurney, Joe E.	Kansas City	**125**
Steele, Jack T.	Bridgeton	**190**
Steenbergen, Michael	Jefferson City	**058**
Steiner, Marvin P.	Independence	**125**
Stocklin, Catherine	St. Louis	**215**
Stone, Kenneth D.	Sikeston	**202**
Stringer, Kenton L.	Aurora	**166**
Stuerman, Lawrence G.	Louisiana	**150**
Suarez, Alberto	Lee's Summit	**125**
Suk, Samuel	Kansas City	**215**
Sultana, Peter	Columbia	**215**
***Tarwater, James K.**	Kansas City	**050**
Tegtmeyer, Chris	Lebanon	**115**
***Terpstra, Gregory K.**	Potosi	**138**
Theby, Janet E.	Eldon	**058**
Thies, Jerome H.	Osceola	**214**
Thomas, Deborah G.	Cape Girardeau	**042**
Thompson, Frederick L.	Nevada	**214**
Thompson, James E.	West Plains	**206**
Thompson, Scott W.	Kansas City	**125**
Till, Bennie N.	Poplar Bluff	**034**
***Tipton, Richard J.,**	Cape Girardeau	**042**
Tobin, Marla J.	Warrensburg	**110**
Treadwell, Randall E.	Chesterfield	**190**
Turner, James D.	Washington	**074**
Turner, Kirby L.	Poplar Bluff	**034**
Uketui, Ozoemenam I.	St. Joseph	**030**
***Upton, Gary L.**	Columbia	**026**
Van Buren, Wilbur D.	Kansas City	**002**
Van Zanten, Niko A.	Osceola	**214**
Vargas, Teodoro C.	Pacific	**190**
Vigneron, Eugene A.	Jefferson City	**058**
Villahermosa, Juanito L.	Savannah	**010**
Voszler, Richard B.	Cape Girardeau	**042**
Ward, Mark R.	Springfield	**082**
Wardell, M. Annette	Springfield	**082**
Watts, Samuel M.	Mt. Vernon	**166**
Weems, Deborah A.	Jefferson City	**058**
Weiss, James J.	Jefferson City	**058**
Welsh, Jon A.	Perryville	**174**
***Wescott, Thomas P.**	Holden	**110**
Weston, Kenneth G.	Columbia	**026**
Wheeler, Robert L.	Harrisonville	**214**
Williams, Paul A.	Kansas City	**125**
Williams, W.A., Jr.	Cape Girardeau	**042**
Williamson, Harold A.	Columbia	**026**
Wilson, David E.	Smithville	**050**
Wilson, Stanley J.	Sedalia	**178**
Wilson, Timothy A.	Kansas City	**050**
***Wilson, W. Timothy**	Springfield	**082**
***Woodward, Owen L.**	Atlanta	**046**
Workman, George M.	Hermann	**074**
***Wright, James C.**	Perryville	**174**
Wulfers, Michael C.	Cape Girardeau	**042**
Wurm, Michael J.	Maryville	**158**
Wurr, Dieter H.	Arnold	**190**
***Yocum, Russell S.**	Platte City	**125**
Young, Robert B.	Rolla	**135**
Zanol, John M.	Columbia	**026**

Gastroenterology (GE)

Allen, Mark J.	Kansas City	**125**
Barber, Gregory B.	Kansas City	**125**
Brock, Arthur L.	Independence	**125**
Clement, Donald J.	Kansas City	**125**
Coleman, Matthew J.	Cape Girardeau	**042**
Coleman, Terrence W.	Liberty	**125**
Cooper, Gary D.	Liberty	**050**
Culver, Perry J., Jr.	Kansas City	**125**
Cusworth, Robert	St. Charles	**189**
***Deffenbaugh, Larry D.**	Joplin	**102**
Edwards, Dean A.	Cape Girardeau	**042**
Elias, Ivan J.	Kansas City	**125**
Farrell, John S.	Bridgeton	**190**
Fedotin, Michael S.	Kansas City	**125**
Frederickson, Neil W.	St. Louis	**190**
Freeman, Michael R.	Cape Girardeau	**042**
Freilich, Brad L.	Kansas City	**125**
Geisman, Richard A.	St. Charles	**189**
Ginsberg, B. William	Kansas City	**125**
Gordon, Glenn L.	Mexico	**014**
Gurian, Lawrence E.	Springfield	**082**
Helzberg, John H.	Kansas City	**125**
Honaas, Trygve O.	Cape Girardeau	**042**
Hover, Alexander R.	Springfield	**082**
Jennett, Richard B.	Jefferson City	**058**
Kaster, Steven D.	Kansas City	**125**
Kipfer, Robert E.	Springfield	**082**
Kouo, Louis	Cape Girardeau	**042**
Landers, Burnell	Independence	**125**
Lee, Wilfred	Cape Girardeau	**042**
Libel, Roy D.	Springfield	**082**
Marshall, Jay P., II	Chesterfield	**190**
McCullough, Joseph E.	Kansas City	**125**
McMahon, Robert	St. Louis	**002**
McPhee, Mark S.	Kansas City	**125**
Mentgen, Carl N.	Springfield	**082**
Merritt, Gregory A.	Kansas City	**125**
Miller, Thomas A.	St. Louis	**002**
Pelican, George	St. Louis	**190**
Petersen, James H.	Chesterfield	**002**
***Schneider, Horace L.**	Cape Girardeau	**042**
Shell, William C.	Sikeston	**202**
Shuler, Frederick N.	Kansas City	**125**
Stein, Bernard	Joplin	**102**
Taormina, Marc K.	Independence	**125**
Walden, David T.	St. Louis	**002**
Wang, Joseph L.	Jefferson City	**058**
Wood, Matthew	Cape Girardeau	**042**
Wooten, Michael B.	Springfield	**082**

General Practice (GP)

Akers, Joan E.	Kansas City	**125**
Akremi, Janet E.	Houston	**206**
Allan, James R.	Columbia	**026**
***Andrews, Lynthia B.**	Lexington	**030**
***Bader, Larry W.**	Columbia	**026**
Baldwin, Theodore R.	Excelsior Springs	**118**
Butler, Susan M.	Jefferson City	**058**
Campbell, James E.	Macon	**046**
Campbell, James W.	Advance	**202**
Carleton, Charles E.	Farmington	**138**
Carpenter, Wallace	Rock Port	**158**
Choudhury, M. Hasan	Springfield	**206**
Conant, James F.	St. Joseph	**030**
***Courter, Gary M.**	Lebanon	**115**
Dettmer, Robert F.	Ironton	**138**
Dudik, Randall G.	Rolla	**135**
Eldenburg, Donald O.	Sedalia	**178**
Frein, Donald E.	Harrisonville	**214**
Gallemore, Rex A.	Neosho	**102**
Gavini, Rajendra R.	St. Louis	**190**
***Gayle, David R.**	Piedmont	**034**
***Gayle, Richard E.**	Piedmont	**034**
Grable, James D.	Cape Girardeau	**042**
Gunn, Jack	Versailles	**120**
Haynie, William W.	Butler	**214**

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Heath, Jimmy D. East Prairie	202
Hettinger, Brenda A. Camdenton	120
Howell, Billy D. Brookfield	078
Howitt, William J. Springfield	082
***Hutchins, Sherry S.** Waynesville	135
Karraker, Alvan G. Farmington	138
Kauffman, Ruth Versailles	120
Ladd, Charles B. St. Louis	190
Lankford, Harold D. Mexico	014
Lichty, Chas A. Shelbina	150
***Lillig, James F.** Kansas City	050
Long, Curtis W. Butler	214
Magaw, David C. Everton	066
Magruder, Lyell M. Nevada	214
McFadden, Gene A. Waverly	118
Menne, Marvin C. Ironton	138
Millwee, Elizabeth M. Centralia	026
Moore, Candice A. Nevada	214
Moore, Michael R. West Plains	206
Morehead, William E. Malden	070
Morris, John J. Columbia	026
Morrison, Thomas A. Aurora	166
Ozenberger, Larry A. Plattsburg	054
Painter, Andrew E. Portageville	202
Pavlu, Robert R. Waverly	118
Pehlman, Joseph E. Malden	070
***Pewitt, Charles S.** Jackson	042
Raynor, Richard C. Marshall	198
Reed, Glen H. Appleton City	214
Rul-Lan, Carlos D. Kansas City	002
Sargent, Alden P. Sikeston	202
Schaaf, Robert O. St. Joseph	030
Scowley, John E. Richmond	118
Shanahan, Philip J. St. Louis	190
Singh, Daljeet R. Higginsville	118
***Smith, James D.** Kirksville	148
Smith, William J. Windsor	086
Taylor, Steve J. Mexico	014
Villarama, Antonio P. High Ridge	190
Vinyard, Jack L. Joplin	102
Williams, Warren I. Milan	148
Won, Russell St. Louis	190

General Preventive Medicine (GPM)

Engelberg, Alan L. Maryland Heights	190

General Surgery (GS)

Abdel-Salam, Ahmed S. Bolivar	066
Aeder, Mark I. Kansas City	125
Afuwape, Emanuel A. E. St. Louis, IL	190
Albano, Benjamin I. Crystal City	106
Allen, Brent T. St. Louis	190
Almiron, Osias A. House Springs	190
Altepeter, H. Martin St. Louis	190
Ancheta, Apolinario A. Springfield	082
Anderson, Charles B. St. Louis	190
Andres, Edward H. St. Joseph	030
Andrus, Charles H. Westchester, IL	190
Apostol, Andres G. Monett	166
Arbab, Ali A. Kansas City	125
Arenos, Proceso T. St. Louis	190
Arnold, Kenneth J. Chesterfield	190
Ashley, Michael E. Springfield	082
Ayvazian, Vatche H. St. Louis	190
Babka, Joseph J. St. Louis	190
Barr, Glenn A. Kansas City	125
Barragan, Hector D. St. Louis	190
Bartlett, Hugh C. Rolla	135
Bass, Barry J. Rolla	135
Bautista, Joel O. Moberly	046
Bautista, Rogelio L. Moberly	046
Beckman, Robert F. St. Louis	002
Beggs, Charles W. Liberty	050
Beheler, Edward M. St. Joseph	030
Behrends, Steven H. Kansas City	125
Behrens, Donald T. St. Louis	190
Benage, Clarence M. St. Louis	190
Bennett, Kenneth J. St. Louis	190
Bentlage, Charles H. Joplin	102
Bergmann, Daniel J. St. Peters	189
Berwald, David M. Bridgeton	190
Betz, Robert F. Neosho	166
Bhattacharya, Arjun St. Louis	190
Billy, Lawrence J. St. Louis	190
Binnington, H.B. St. Louis	190
Birnbaum, Elisa H. St. Louis	190
Bizek, J.L. Aurora	166
Blank, Michael K. DeSoto	106
Blanke, Thomas J. St. Louis	190
Braverman, Stuart J. Sedalia	178
Brunt, L. Michael St. Louis	190
Buchele, Alan Morrow Joplin	102
Buckner, John W. Springfield	082
Buettner, John Brigham Chesterfield	190
Bukstein, Michael J. Hannibal	150
Bumberry, John R. Springfield	082
Bussmann, Carl E. Bridgeton	190
Cabrera, Tomas V. St. Peters	189
Cannon, Max K. Kirksville	148
Cardwell, Daniel R. Bolivar	066
Cassat, James D. Washington	074
Castaneda, Marco A. Bridgeton	190
Catanzaro, Rudolph E. St. Louis	190
Cheuk, Shu-Sum Chesterfield	190
Christiansen, Stephen D. Springfield	082
Christy, John P. Poplar Bluff	034
Chu, Peter Y. Kansas City	125
Chung, Kap Eun Fredericktown	138
Chung, T. David Poplar Bluff	034
Codd, John E. Bridgeton	190
Corrado, Joseph A. Mexico	014
Corry, Francis M. Springfield	082
Coscia, Robert L. Springfield	082
Craighead, Michael L. Jefferson City	058
Crighton, John C. Springfield	082
Critchlow, J. Thomas Cape Girardeau	042
Daake, John W., Jr. St. Louis	190
Dandridge, Walter C. Joplin	102
Doerhoff, Alan R. Jefferson City	058
Doerhoff, Carl R. Jefferson City	058
Dominquez, Jose M. Springfield	082
Donovan, John F. St. Louis	190
Dunn, Charles W. Springfield	082
Elfrink, Roy J. Marshall	198
Esparrago, F.R. Monett	166
Evans, Joseph C., Jr. Independence	125
Fabito, Daniel C. St. Louis	190
Fahrner, Mari A. Chesterfield	190
Fallon, Richard H. St. Louis	190
Floro, Kenneth E., Jr. St. Louis	190
Floro, Mariano N. Florissant	190
Foreman, Phillip B. Hannibal	150
Fraser, Daniel M. St. Louis	190
Frohman, Boris Sikeston	202
Gerowin, Lance St. Louis	190
Gibson, James D. Springfield	082
Gieselmann, James W. Poplar Bluff	034
Glenn, Edward A. Louisiana	150
Gomez, Cesar A. St. Louis	190
Gosek, Marek J. Warrensburg	110
Graff, Ralph J. St. Louis	190
Greene, Howard G. Louisiana	150
Guerra, Gaston G. Kansas City	125
Hahn, Bruce H. Lee's Summit	125
Hanna, Hugh A. Warrensburg	110

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GENERAL SURGERY

Hanson, Morin M.	St. Louis	190
Harms, James F.	Nevada	214
Harris, Hugh S., Jr.	Columbia	026
Hayek, Michael E.	St. Louis	190
H'Doubler, Charles	Mt. Vernon	082
H'Doubler, Francis T.	Springfield	082
H'Doubler, Peter B.	Springfield	082
Heeb, Max A.	Sikeston	202
Helfrich, Loring	Sikeston	202
Helling, Thomas S.	Kansas City	125
Hendren, Thomas H.	Liberty	050
Hill, Ronald T.	Dexter	202
Hoberock, Thomas R.	Branson	208
Hoehn, John P., III	St. Louis	190
Hornbostel, Phillip M.	Sedalia	178
Howard, Todd K.	St. Louis	190
Hunt, Robert S.	Cape Girardeau	042
Ivins, Gregory K.	Fulton	038
James, Kathleen M.	St. Charles	189
James, Kelly M.	Independence	125
Jensen, Joshua E., II	St. Louis	190
Jew, Amie C.	Overland Park, KS	125
Johnson, Frank E.	St. Louis	002
Kakaiya, Dilip H.	Kennett	070
Kang, Young M.	West Plains	206
Kasten, Melvin C.	Cape Girardeau	042
Kiev, Jon	Hannibal	150
Kinder, Jerry L.	Cape Girardeau	042
King, Frank K.	Hayti	170
Kingsbury, Robert J.	St. Peters	189
Knight, James W.	St. Louis	190
Knopf, Simon L.	Kansas City	215
Koivunen, Debra G.	Columbia	026
Krajcovic, David P.	Chesterfield	190
Kuvshinoff, Boris W.	Columbia	026
Larson, Kenneth W.	Springfield	082
Laster, Jerry L.	Joplin	102
LaHue, William C.	Lexington	118
Levy, Jerome F.	St. Louis	190
Liang, Jing C.	Independence	125
***Light, Diane L.**	Jefferson City	058
Limpiphiphatn, Dhajphong	Perryville	174
Londe, Alan M.	St. Louis	190
London, Stanley L.	St. Louis	190
Long, W. Steven	St. Joseph	030
Lopez-Plata, Roberto	Leawood, KS	125
Lowell, Jeffrey A.	St. Louis	190
Ludwig, Mark A.	St. Louis	190
Lugo, Saml	St. Louis	190
Lundman, Hugh	Springfield	082
Madrid, Dominador O.	St. Louis	190
Marr, Garrett L.	Kansas City	125
Martin, Clarence A.	Joplin	102
Mayuga, Laureano G.	Cabool	206
McCroskey, Lon C.	Kansas City	125
McGinty, Frank H.	Cape Girardeau	042
McGregor, Patrick E.	N. Kansas City	050
Meier, Mitchell S.	Joplin	102
Metzler, Michael H.	Columbia	026
Meyer, Robert C.	St. Louis	190
Meyers, Jerry R.	St. Peters	189
Miedema, Brent W.	Columbia	026
Mitchell, Franklin L.	Columbia	026
Moffe, Thomas C.	Springfield	082
Monafo, William W.	St. Louis	190
Morehouse, Paul D.	Washington	074
Muhm, H. Yale	St. Charles	189
Mulder, George D.	St. Joseph	030
Mutchnick, Norman	Kansas City	125
Nagle, Michael G.	Joplin	102
Nathan, Lester J.	Fenton	190
Near, David M.	Florissant	190
Newman, Joseph A.	Joplin	102
Ng, Edmond K.	St. Louis	215
Niesen, Frank J.	St. Louis	190
Niesen, Thomas E.	Chesterfield	190
Nigro, Thomas L.	Kansas City	125
Norton, Jeffrey A.	St. Louis	190
Nwaobasi, Sam	Florissant	190
Occeno, Victor G.	Cassville	166
Ochoa, Pedro	Valmeyer, IL	190
Olive, G. Chapman	Springfield	082
Oliver, George A.	Farmington	138
Olson, Richard O.	St. Charles	189
Ong, Eng L.	St. Louis	190
Parikh, Sharad P.	Florissant	190
Parks, Charles	St. Louis	190
Parulekar, Dilip G.	Fulton	038
Peick, Ann C.	Poplar Bluff	034
Pennell, Richard C.	St. Louis	190
Perez, Adamor R.	St. Louis	190
Perll, Peter D.	Mexico	014
Petelin, Joseph B.	Shawnee Mission, KS	125
Peters, Walter R.	Columbia	026
Petit, Carl A.	Osage Beach	120
Philpott, Gordon W.	St. Louis	190
Pitsinger, N. Bruce	Chesterfield	190
***Pitt, James B.**	Osage Beach	120
Pontillas, Job B.	Perryville	174
Porvaznik, John T.	Chesterfield	190
Prasad, Chandra N.	Jefferson City	058
Previti, Vincent	Springfield	082
Pruett, Don S.	St. Louis	190
Radford, Diane M.	St. Louis	190
Rao, Ricardo	Chesterfield	190
Reardon, Thomas M.	N. Kansas City	050
Reese, Jon A.	Springfield	082
Reister, Philip D.	Kansas City	125
Rendleman, George F., Jr.	St. Louis	190
Richardson, Donna T.	Union	074
Richardson, Norbert L.	Union	074
Richmond, Ron	Cape Girardeau	042
Riechers, Thomas B.	Washington	074
Roberts, Jonathan M.	Jefferson City	058
Rodriguez, Gregorio L.	Charleston	202
Rodriguez, Ubaldo R.	St. Louis	190
Roh, Joseph J.	Kansas City	125
Rosenbloom, Michael	Hollywood, FL	190
Rubin, Brian G.	St. Louis	002
Runez, Manuel W.	Maryville	158
Safley, Thomas J.	Independence	125
Schaefer, Glennon S.	St. Louis	190
Schlarman, David E.	St. Louis	190
Schneider, Thomas A.	St. Charles	189
Schrodt, Rudolph	St. Louis	215
Schuh, Marlys E.	Creve Coeur	190
Scott, Joni C.	Springfield	082
Sharlow, Joseph W.	Ste. Genevieve	174
Shine, Thomas E.	St. Louis	190
Shoults, Nicholas F.	Springfield	082
Sicard, Gregorio A.	St. Louis	190
Snyder, Charles L.	Overland Park, KS	125
Southgate, Theodore J.	Cape Girardeau	042
Spadone, Donald P.	Columbia	026
Standiford, Steven B.	Columbia	026
Steiling, Sylvia A.	St. Louis	190
Strasberg, Steven M.	St. Louis	190
Stubbs, Thomas R.	West Plains	206
Sugarbaker, Stephen P.	Jefferson City	058
Switzner, Diane L.	Springfield	082
Tang, Teodoro	Salem	135
Tenorio, Arturo A.	Stanberry	158
Terry, Boyd E.	Columbia	026
Terschluse, David A.	Bridgeton	190
Thornton, Fred H.	Sikeston	202
Trinidad, Hermanito R.	Chillicothe	078
Troop, Bryan R.	St. Louis	190
Tucker, George L.	Chesterfield	190

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Turner, William A.	214	Nevada
Underwood, Johnson, III	050	N. Kansas City
Upadhyay, Ajay K.	138	Fredericktown
Verzola, Eufemio G.	106	Herculaneum
Vidals, Victor G.	125	Kansas City
Viloria, Alberto B.	190	St. Louis
Vitale, Thomas J., Jr.	190	St. Louis
Wade, Scott A.	030	St. Joseph
Wadley, John J.	178	Sedalia
Waldschmidt, Mike L.	125	Liberty
Waltz, James R.	050	Liberty
Webb, John M.	125	Kansas City
Wells, Samuel A., Jr.	190	St. Louis
Werner, F. Scott	050	N. Kansas City
Westerman, Robert N.	190	St. Louis
Westfall, Scott G.	190	Chesterfield
Westfall, Susan H.	190	Chesterfield
Wetzel, C. Robert	086	Clinton
Wetzel, Gus S.	086	Clinton
Willcoxon, Robert L.	102	Joplin
Williams, John R., Jr.	189	St. Charles
Windmiller, M. Eugene	026	Columbia
Wittmer, Marc R.	082	Springfield
Wonder, Donald	208	Branson
Woods, John J., Jr.	190	St. Louis
Yap, Mardonio J.	190	Florissant
Yates, William D.	190	St. Louis
Zacharias, Kulangara P.	026	Columbia

Gynecology (GYN)

Alderman, Lillian C.	050	Liberty
Bopp, J. Ronald	102	Seneca
Jacob, Joe	026	Columbia
Patterson, Donald C.	026	Columbia
Roberts, Howard H.	102	Joplin

Schmidt, Herbert J.	102	Joplin
Watson, Trevor F.	026	Columbia
Williams, Carol F.	190	St. Louis

Hematology (HEM)

Abbey, Elliot E.	002	St. Louis
Bayer, William L.	125	Kansas City
Carden, Juan O.	190	St. Louis
Carter, Robert L.	102	Joplin
Chan, Celia L.	042	Cape Girardeau
Davidner, Mark L.	125	Kansas City
Davis, Kimberly K.	125	Independence
Geller, Robert B.	125	Kansas City
Gomez, Patrick L.	082	Springfield
Grant, Ruth	082	Springfield
Loftus, Loretta S.	125	Kansas City
Minkoff, I. Monica	189	St. Peters
Monaghan, Greg G.	026	Columbia
Muscato, Joseph J.	026	Columbia
Muscato, Mary S.	026	Columbia
Peterson, Jay T.	125	Kansas City
Ratkin, Gary A.	190	St. Louis
Vellek, Mark J.	026	Columbia
Watanabe, Massayo	125	Kansas City
Weigand, Robert T.	030	St. Joseph
Woodson, Mark E.	190	St. Louis

Head & Neck Surgery (HNS)

Seabaugh, Janice L.	042	Cape Girardeau
Sudekum, Anthony E.	189	Defiance

Hand Surgery (HS)

Wyrsch, Robert B.	082	Springfield

Infectious Diseases (ID)

Brewer, Joseph H.	125	Kansas City
Driks, Michael R.	125	Kansas City
Fried, John S.	125	Overland Park, KS
Haddow, Alastair D.	082	Springfield
Henry, R. Beth	125	Kansas City
Hinrichs, James H.	190	Bridgeton
McKinsey, David S.	125	Kansas City
Neihart, Robert E.	125	Kansas City
Prost, Monika M.	026	Columbia
Sistrunk, William W.	002	Springfield
Smith, David Lambuth	125	Kansas City
Spernoga, John F.	190	St. Louis
Winton, Mark D.	058	Jefferson City

Internal Medicine (IM)

Abel, Charles C.	190	St. Louis
Abinoja, Conrado B.	190	St. Louis
Aguinaldo, Jaime A.	190	St. Louis
Ahadi, Abd U.	190	St. Louis
Ahern, Archibald M.	190	St. Louis
Ahmad, Musaddeque	138	Potosi
Ahmad, Naseer	190	St. Louis
Ahmad, Shahzad	202	Sikeston
Albano, Grace A.	125	Lee's Summit
Aldasouqi, Saleh	042	Cape Girardeau
Alegre, Jorge M.	190	Chesterfield
Allen, Thomas P.	125	Overland Park, KS
Allyn, Steven L.	082	Springfield
Almond, Toni	026	Columbia
Alonso-Yague, Pascual	190	Florissant
Alvarez, Juan M.	190	St. Louis
Alvarez, Ulises C.	190	Florissant
Andrews, Paul E.	082	Springfield
Anslinger, David L.	190	Chesterfield
Atkinson, John P.	190	St. Louis
Atwood, Steven D.	082	Springfield
Avioli, Louis V.	190	St. Louis
Aydt, Sarah A.	042	Cape Girardeau
Azan, Kenneth N.	178	Sedalia
Azrak, Elie	215	Chesterfield
Baak, Steven W.	190	St. Louis
Back, Donald K.	082	Springfield
Backstrom, Jay T.	125	Kansas City
Baker, Tim E.	074	Washington
***Balcer, Conrad S.**	058	Jefferson City
Banchs, Jose	215	St. Louis
Banton, M. Roman	190	St. Louis
Barjenbruch, Peggy W.	014	Mexico
Barnes, Larry G.	166	Neosho
***Barnum, Grant M.**	120	Osage Beach
Barrido, Lemuel T.	138	Potosi
Barrow, Jack	190	St. Louis
Bartell, Michael F.	190	St. Louis
Bauer, Daniel J.	190	St. Louis
Bautz, James B.	125	Kansas City
Bauwens, Daniel B.	190	Chesterfield
Bavlsik, Michael D.	002	St. Louis
Beato, David L.	190	St. Louis
Benedict, William W.	190	Chesterfield
Bentley, John D.	082	Springfield
Berdy, Susan S.	190	St. Louis
Berkowitz, Ellis R.	030	St. Joseph
Bernstein, Aaron M.	190	St. Louis
Best, John A.	190	Chesterfield
Bettonville, Peter V.	190	St. Louis
Betz, Richard J.	166	Neosho
Biggs, Alfred D., Jr.	125	Kansas City
Birge, Clifford A.	190	St. Louis
Blackburn, Timothy L.	125	Kansas City
Blum, Donald A.	190	St. Louis
Boldt, Thomas H.	190	Bridgeton

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Bonsanti, Robert L.	190	Bridgeton
Boonshaft, Benje	190	St. Louis
Borja, Egbert R.	082	Springfield
Borowsky, Benj A.	190	St. Louis
Borrego, Raul A.	138	Farmington
Bowe, Christopher C.	190	St. Louis
Bowles, G.R.	190	St. Louis
Bownik, T. Bryan	050	Kansas City
Boyer, Peter A.	058	Jefferson City
Bregant, Robert E.	058	Jefferson City
Breite, Warren M.	106	Festus
Brinkman, Robert A.	190	Chesterfield
Broaddus, Loren E.	082	Springfield
Brockman, M. Douglas	082	Springfield
*Brocksmith, James T.	026	Columbia
Brody, Arnold G.	190	St. Louis
Broun, Goronwy O., Jr.	190	St. Louis
Brown, Barry D.	190	St. Louis
Bryant, T.J.	125	Kansas City
Budd, John J., Jr.	190	St. Louis
Burmeister, R. William	190	St. Louis
Burns, Edward L.	190	St. Louis
Burns, Thomas W.	026	Columbia
Burris-Velloff, Tara M.	125	Prairie Village, KS
Buse, Paul E.	190	St. Louis
Butin, Richard E.	125	Kansas City
Butsch, Richard H.	190	St. Peters
*Byrne, Kevin G.	120	Osage Beach
Cabral, Galileu	190	Florissant
Cadiz, Briccio S., III	174	Ste. Genevieve
Caldwell, Fred M.	034	Poplar Bluff
Camp, Alan D.	002	Bridgeton
Campbell, J. William	190	St. Louis
Canby, Robert C.	125	Kansas City
Cannistraro, Rosemary L.	190	Clayton
Carmody, John P.	190	St. Louis
Cary, John M.	190	Chesterfield
Cavero, Fernando L.	066	Bolivar
Chand, Nilima P.	138	Bonne Terre
Chand, Sunil C.1	38	Bonne Terre
Chandramohan, Nanjappa	102	Carthage
Chantler, Marcia L.	215	St. Louis
Charles, Francois	190	St. Louis
Chase, Larry K.	082	Springfield
Chaudhuri, Tapan K.	125	Lee's Summit
Chern, Mou S.	206	Ava
Chernoff, Selbert G.	125	Lee's Summit
Chin, Mark Maw-Chang	190	Chesterfield
Chouinard, Michael P.	202	Sikeston
Clark, David P.	026	Columbia
Clark, Robert C.	030	St. Joseph
Coates, James G.	002	St. Louis
Cochran, Thomas E.	082	Springfield
*Cohen, Donald L.	125	Overland Park, KS
Cohen, Faye C.	190	Chesterfield
Cohen, Hillard K.	190	St. Ann
Colbert, Dennis G.	190	St. Louis
Conger, Susan C.	190	St. Louis
Convery, Paul B.	190	St. Louis
Cooper, Barry J.	190	St. Louis
Copp, Ralph	190	St. Louis
Coppinger, Thomas A.	125	Kansas City
Corder, James C.	190	St. Louis
Cort, David H.	190	St. Louis
Crespin, Stephen R.	190	St. Louis
Crie, J. Stanley	030	St. Joseph
Crockett-Maples, Melinda	082	Springfield
*Crowell, Tamara E.	1 25	Lee's Summit
Cruz, Sergio G.	166	Monett
Cryer, Philip E.	190	St. Louis
Cuddihee, Robert E.	190	St. Louis
Cummings, Steven W.	190	Brentwood
Cunningham, Edwin J.	190	Chesterfield
Curry, Michael J.	189	St. Charles
Custer, Galen M.	125	Overland Park, KS
*Daly, Michael M.	026	Columbia
Dames, Richard J.	190	Chesterfield
Daniels, John S.	002	St. Louis
Danuser, Carol B.	026	Columbia
Deckard, Shelby W.	082	Springfield
Delcambre, Marie A.	125	Kansas City
Dembinski, David R.	125	Kansas City
Desai, Alpana A.	215	St. Louis
Dew, Thomas A.	190	Chesterfield
Dexter, J. Kent	082	Springfield
DeBelen, Arnold Z.	150	Canton
DeFeo, Frederick G.	125	Kansas City
Diestelhorst, James A.	190	St. Louis
Dieterle, Brian D.	208	Branson
DiPasco, Donald J.	190	St. Louis
DiValerio, Richard M.	190	St. Louis
Doak, Gregory A.	178	Sedalia
Dorton, Robert K.	190	St. Louis
Dorzab, Linda L.	125	Raytown
Dotson, Lori J.	026	Boonville
Duff, James E.	082	Springfield
Duff, John A.	082	Springfield
DuMonteer, Gary	074	Washington
Early, Dayna S.	026	Columbia
Ellzey, Barbara A.	190	St. Louis
Emerson, William A.	190	St. Louis
Emons, Matthew F.	190	Louisville, KY
Enriquez, Roman S.	125	Kansas City
*Entrup, Mark H.	082	Springfield
Evans, Andrew L.	082	Springfield
Faddis, Mitchell N.	190	St. Louis
Farnham, Milo M.	125	Independence
Farrell, Thomas M.	002	St. Louis
Faruqi, Sohaib A.	138	Potosi
Favors, Adolphus C., Jr.	190	St. Louis
Fedor, Barbara A.	082	Springfield
Ferrara, Robert P.	190	St. Louis
Figueroa, Eliseo O.	190	St. Louis
Fischer, Robert	190	St. Louis
Fishman, Norman	190	Chesterfield
Fitch, Coy D.	190	St. Louis
Fleming, David A.	046	Moberly
Fleming, J. Will, Jr.	046	Moberly
Flicker, Michele R.	125	Bridgewater, NJ
Flotte, Sylvester A.	190	St. Louis
Flury, Kirk E.	190	St. Louis
Fogarty, William M., Jr.	190	St. Louis
*Frank, Robert A.	125	Independence
Fraser, Victoria J.	190	St. Louis
Froehlich, Thomas W.	082	Springfield
Galant, Mark R.	125	Belton
Galbreath, Ashford M., Jr.	125	Kansas City
Gale, Arthur H.	190	St. Louis
Galvez, Sisenando P.	078	Marceline
Garcia, Juan C.	190	St. Louis
Garcia, Kathleen M.	190	St. Louis
Garfinkel, Bernard T.	190	St. Louis
Garriga, Francisco J.	190	Florissant
Gatchalian, Felicitas Z.	190	St. Louis
Gedney, William B.	190	Valley Park
Geier, David L.	082	Springfield
Gendel, Jonathan	125	Lee's Summit
Gentsch, Kenneth W.	190	St. Louis
George, David	215	St. Louis
Ghazal-Albar, Naman	150	Louisiana
Ghosh, Nellie	190	St. Louis
Gill, Paul J.	082	Springfield
Ginardi, Donald E.	125	Kansas City
Ginther, James W., Jr.	190	St. Louis
Giorgi, Lee V.	125	Kansas City
Glazer, Melvin L.	125	Kansas City
Godwin, Lehman W.	082	Springfield
Goldman, Arnold M.	190	St. Louis

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Goldman, Barry C.	125	Kansas City
Goodenberger, Daniel M.	190	St. Louis
Goodwin, J. Wendall	082	Springfield
Gordon, Mark E.	050	N. Kansas City
Gould, Ronald J.	190	St. Louis
Grady, Ronald K.	190	Chesterfield
***Graessle, Donna M.**	125	Shawnee, KS
Grant, Neville	190	St. Louis
Gray, Gary J.	190	St. Louis
Greco, Thomas J.	190	St. Louis
Greenlaw, Cal W.	078	Chillicothe
Gregory, Mark H.	190	St. Louis
Griesbaum, Robert V.	190	St. Louis
Groll, John R.	190	St. Louis
Gruenebaum, Steven A.	125	Kansas City
***Gryte, Rolf R.**	120	Osage Beach
Gupta, Vicram	030	St. Joseph
Gutierrez, Ernesto	190	Florissant
Guyol, William B., Jr.	190	St. Louis
Gwin, Edward	082	Springfield
Hagemann, Margarethe H.	190	St. Louis
Hagen, Garrett A.	190	St. Louis
Hale, Thomas H.	190	Manchester
Haleem, Usman	215	St. Louis
Hall, Deborah M.	125	Overland Park, KS
Halloran, Mark J.	190	St. Louis
Halpin, Stephen E.	150	Hannibal
Halsted, Robert W.	074	Washington
Halsted, Teresa M.	074	Washington
Hamburg, Eric D.	138	Farmington
Hamid, Zahid	158	Mound City
Hammerman, Marc R.	190	St. Louis
Hardy, Patrick J.	190	Florissant
Hardy, Samuel W.	190	St. Louis
***Harris, William D.**	125	Lenexa, KS
Hawatmeh, Isam	190	St. Louis
Hegde, Korgi V.	190	St. Louis
Heins, James N.	190	St. Louis
Hellam, Duane C.	082	Springfield
Henry, Joseph E.	050	Shawnee Mission, KS
Herfkens, Kenneth D.	082	Springfield
Hernandez, Richard P.	138	Cape Girardeau
Hill, M. Robert	190	St. Louis
Hintze, Paul F.	190	Chesterfield
Hoeman, Michael D.	082	Springfield
Hoeper, Samuel D., Jr.	125	Kansas City
Hoffman, Leanna M.	078	St. Joseph
Hoffmann, Sandra S.	190	Chesterfield
Hogan, Cornelius E.	190	St. Louis
Hogan, John R.	190	St. Louis
Holkins, John M.	125	Kansas City
Hoover, Bernard L.	190	St. Louis
Horine, Jon A.	125	Kansas City
Hu, Raymond J.	189	St. Peters
Huck, Richard F., Jr.	190	St. Louis
Husted, Frederick C.	082	Springfield
Hyatt, Robert W.	058	Jefferson City
Inman, Max M.	190	Chesterfield
Irvin, William S.	026	Columbia
Jackson, Dorothy J.	125	Kansas City
Jafri, Syed F.	078	Hamilton
Jain, Poonam M.	190	Ballwin
Jain, Sandeep	215	St. Louis
Jain-Roberts, Sangeeta	058	Jefferson City
Jakoby, Michael G., 1V	190	St. Louis
Jamison, Kimberly	026	Columbia
Jantz, Keith	125	Kansas City
Jarvis, Cathy C.	190	Florissant
Javdan, Ron	190	St. Louis
Jayamanne, Damasus S.	058	Jefferson City
Jedlinski, Michael T.	042	Cape Girardeau
Johnson, Eric J.	002	Chesterfield
Johnson, Warford B., 11	082	Springfield
Joseph, Harold J.	190	St. Louis
Josyula, Bhagavan V.	002	St. Louis
Jotte, Richard P.	190	St. Ann
***Joubert, Paul M.**	125	Lee's Summit
Juergens, William G.	190	St. Louis
Kanagawa, Harold K.	058	Jefferson City
Kandula, Madhavi	190	St. Louis
Kantor, Owen	190	St. Louis
Kardesch, Milton	190	St. Louis
Karsh, Robert S.	190	St. Louis
Katragadda, Rajsndra P.	002	Kansas City
Katsiyiannis, William	215	St. Louis
Kaufman, Robert L.	190	St. Louis
Kauk, Bruce A.	050	N. Kansas City
Kaup, Chandra S.	190	Florissant
Keairnes, Harold W.	125	Kansas City
Kelly, John J.	190	St. Louis
Kerkemeyer, George	150	Hannibal
Kichura, George M.	190	St. Louis
Kiehl, Mary M.	190	St. Louis
Kim, Chul	034	Poplar Bluff
King, Donald K.	190	St. Louis
King, Tinna P.	190	St. Louis
Kinsella, Peter W.	190	St. Louis
Kipnis, David M.	190	St. Louis
***Kirila, Carol E.**	002	Kansas City
Kirkland, Jerry A.	050	Kansas City
Kissell, Richard W.	082	Springfield
Klachko, David M.	026	Columbia
Klearman, Micki	190	St. Louis
Knight, William A., Jr.	190	St. Louis
Knowlton, Norman P., III	082	Springfield
Kohler, Roy	082	Springfield
Kolb, Lisa G.	058	Jefferson City
Kopp, Kenneth R.	125	Lenexa, KS
Kreski, Kenneth C.	190	House Springs
Krewet, Frank A., III	190	St. Louis
Kriegshauser, James W.	190	St. Louis
Kronemer, Keith A.	190	Chicago, IL
Kuangparichat, Manoch	118	Excelsior Springs
Kuhlman, Ralph F.	190	St. Louis
Kunst, Edward J.	190	Ballwin
Laird, John M.	190	St. Louis
Landau, David W.	190	St. Louis
Landsbaum, Charles J.	058	Jefferson City
Latif, Azhar	118	Lexington
Lauer, Danl J.	125	Overland Park, KS
***Lawson, Gina E.**	002	Smithville
LaMonda, Gary W.	026	Columbia
LaPietra, Martha M.	125	Kansas City
Leeper, Sidlee W.	026	Rocheport
Lehman, Robert B.	190	St. Louis
Leightner, William F.	190	St. Louis
Leitch, Steven M.	082	Springfield
Letizia, Wayne L.	125	Independence
Levy, Morton A.	190	St. Louis
Lewandowski, Molly J.	125	Leawood, KS
Lieberman, David M.	190	St. Louis
Lila, Aram	050	Excelsior Springs
Lilly, Douglas R.	190	St. Louis
Lin, H. T.	046	Moberly
Lindeman, John F.	190	Chesterfield
Little, Blake A.	102	Joplin
Lockard, Orlyn O.	030	St. Joseph
Loeb, Richard H.	082	Springfield
Loeffler, Roberta L.	190	Wikchita, KS
Long, Priscilla E.	150	Hannibal
Loomis, James F.	190	St. Louis
Lovinger, Warren C., Jr.	214	Nevada
Lubowitz, Herbert	190	St. Louis
Lyons, Daniel F.	082	Springfield
Lyss, Carl A.	190	St. Louis
Maben, Sam E.	125	Kansas City
Mack, Marvin L.	026	Columbia
Macleod, Angus	190	St. Louis

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MacGorman, Linda R.	Springfield	082
Majors, Patrick F.	St. Louis	190
Malhotra, Vikas	Waynesville	135
Mallouk, Alexander G.	Kansas City	125
Mantell, Jack M.	Springfield	082
Margolis, David M.	St. Louis	190
Martin, Chris J.	Columbia	026
Martin, Mary E.	St. Louis	215
Mass, Joan H.	St. Louis	190
Mathews, Jeffrey E.	St. Louis	190
Mayus, Joseph L.	Springfield	082
McCarthy, Christopher E.	St. Louis	190
McCool, James F.	St. Louis	190
McCormack, Robert E.	Kansas City	125
McDonald, James H.	Kansas City	125
McDonald, Wallace	St. Joseph	030
McGovney, Janice K.	Kansas City	050
McKeel, Thomas B.	Kansas City	125
McKinley, Lois J.	Kansas City	125
McLemore, Willie O.	Kansas City	125
McMillan, David L.	Neosho	166
McMillen, James J.	St. Joseph	030
*McNabb, M. Jeffery	Cape Girardeau	042
McNay, Jennifer A.	Springfield	082
Mecker, Robert	Washington	074
Mehra, Ravi	St. Louis	190
Meidl, Erik J.	Hannibal	150
Mejia, Victor E.	Sikeston	202
Meldi, Dominic M.	Springfield	082
Meltz, Gary J.	St. Charles	189
Mendelsohn, Robert S.	St. Louis	190
Merritt, Robert F.	Sedalia	178
Metry, Donald J., Jr.	Chillicothe	078
Mihalevich, John A., Jr	Springfield	082
Miles, Richard W.	Joplin	102
Miller, Dace L.	Springfield	082
Miller, Donald	Jefferson City	058
Mills, Melissa J.	Overland Park, KS	002
Minnigerode, Turner L.	Kansas City	125
Miskovsky, Emil F.	St. Louis	190
Mitchell, Lynn D.	Columbia	026
*Mitchem, Randall E.	Jefferson City	058
Mohs, Frank R.	St. Louis	190
Molavi, Rameen J.	St. Louis	215
Molden, C. Scott	St. Louis	190
Monaco, Michael	Harrisonville	125
Montgomery, Austin F.	St. Louis	190
Moore, John M.	Kansas City	002
Morgan, Vincent I.	Cameron	054
Moriconi, William J.	St. Louis	190
Morris, J. H.	Independence	125
Morton, David J.	St. Louis	190
Motchan, Dennis G.	Bridgeton	190
Mruk, Jozef S.	St. Joseph	030
Muchnick, Richard L.	St. Louis	190
Muegge, F. David	Springfield	082
Muhammud, Faquir	St. Louis	190
Mullen, Mary E.	Mexico	014
Mullican, Charles N.	St. Joseph	030
Mullins, John E.	Chesterfield	190
Murphy, Daniel J.	Bridgeton	190
Murphy, Margaret A.	St. Louis	190
Nanson, Duane	Columbia	026
Narayan, Dilip L.	Chesterfield	190
Narkiewicz, Lawrence S.	St. Louis	190
Nelson, Donald C.	Springfield	082
Nelson, J. Roger	St. Louis	190
Nguyen, Khanh X.	Lenexa, KS	002
Nicholas, Stephen P.	St. Louis	190
Nickell, Michael D.	Joplin	102
Niesen, Anna R.	St. Louis	190
Nix, J. Gustavo	Bolivar	066
Norland, Charles C.	St. Louis	190
Novack, Mark A.	Chesterfield	190
Nulton, Carnie C.	Kansas City	125
Nyazee, Muhammad A.	Florissant	190
Nye, Terry R.	Springfield	082
O'Connor, Mary C.	Kansas City	125
O'Donnell, Susan M.	Ste. Genevieve	174
O'Keefe, James H., Jr.	Kansas City	125
O'Toole, Lisa	Overland Park, KS	125
Ockner, Samuel A.	Chesterfield	190
Olsen, Teresa A.	Springfield	082
Olson, James H.	Liberty	050
Orgel, S. Michael	St. Louis	190
Orlando, Louis A.	Kansas City, KS	125
Ortbals, David W.	Chesterfield	190
Ovens, Lisa	Springfield	082
Owen, Robert F.	St. Louis	190
Packman, Robert C.	St. Louis	190
Palazola, Joseph M.	Kansas City	125
Paletta, Frank	St. Louis	190
Paletta, Victor L.	Bridgeton	190
Paone, Douglas B.	Kansas City	125
Park, Duk J.	Festus	106
Parks, Deborah L.	St. Louis	190
Patel, Dilip H.	St. Louis	190
Patel, Indu B.	Barnhart	106
Peck, William A.	St. Louis	190
Pereira, Mary Beth	St. Louis	190
Perez, Robert J.	St. Louis	190
Perll, Michael F.	Kansas City	125
Perryman, J. Chris	Kansas City	125
Pfefer, Leland U.	Columbia	026
Pfefferkorn, David A.	Sikeston	202
Phillips, William J.	Chesterfield	190
Pickering, Lee I.	Independence	125
Piening, Kurt A.	St. Charles	189
Pierce, Dan L.	Columbia	026
Pineda, Hector O.	St. Louis	190
Pineda, Juan J.	Columbia	026
Podolsky, Howard S.	St. Louis	002
*Poepsel, Philip R.	Bridgeton	190
Pogson, George W., III	Independence	125
Pohlman, Thomas M.	Chesterfield	190
Ponstingl, Raana J.	St. Louis	190
Postma, George S., Jr.	Mission, KS	125
Potts, Dan E.	Chesterfield	190
Powell, Kenneth R.	Springfield	082
Prelutsky, David J.	St. Louis	190
Proskey, Vincent J.	Chesterfield	190
Purcell, Henry E.	St. Louis	190
Purcell, Richard D.	Springfield	082
Puro, Edward A.	Florissant	190
Pyszczynski, Dennis R.	Kansas City	125
Qureshi, Abdul R.	St. Louis	190
Rabang, Lazaro U.	Bethany	078
Raju, Niranjana	Ste. Genevieve	174
Ramirez, Samuel G.	St. Louis	190
Ramsey, Robert H.	Bridgeton	190
Randolph, Kerry A.	Springfield	082
Ranginani, Anil K.	Savannah	010
Rangineni, Rajagopal	St. Joseph	030
*Rankin, W. Dale	Joplin	102
Rau, Michael E.	Washington	074
Rauba, Alan T.	Jefferson City	058
Raybould, Michael W.	Kansas City	125
Razzaq, A.	St. Louis	190
Rearden, Timothy P.	St. Louis	190
Reardon, Thomas F.	St. Louis	190
Redington, James C., Jr.	St. Louis	190
Redmon, Conchita M.	Springfield	082
Reeder, Stephen M.	Springfield	082
Reh, Edward P., Jr.	St. Louis	190
*Reinbold, Thomas R.	Houston	206
Reynolds, James A.	Chesterfield	190
Rice, Karen H.	Jefferson City	058
Richards, Dean D., III	Overland Park, KS	125

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Riley, Joel Y.	St. Louis	002
Riojas, Lisa A.	Rolla	135
Rippe, William F.	St. Joseph	030
Robinson, Nicholas F.	Kennett	070
Robinson, Ronald L.	Cape Girardeau	042
Rogers, James T.	Springfield	082
Romaker, Ann M.	Kansas City	125
Rosecan, Marvin	Belleville, IL	190
Rosen, Larry A.	Independence	125
Rosenberg, David S.	Florissant	190
Ross, Robert M.	Kansas City	125
Rouse, Ernest T., III	St. Louis	190
Roxas, Generoso P.	St. Charles	189
Russell, John J.	Cape Girardeau	042
Salibi, Habbouba	Chesterfield	190
Samet, John M.	St. Louis	190
Samuel, George P.	Doniphan	034
Sanchez, Archie J.	Kansas City	002
Sandiford, Patrick	St. Charles	189
Sanfelippo, John F.	Jefferson City	058
Sarma, Anuradha H.	Lee's Summit	125
Schell, James A.	Columbia	026
Scheperle, Mark A.	St. Louis	190
Schierman, William D.	St. Louis	190
Schmid, Tania L.	St. Louis	190
Schmidt, Edwin H., III	St. Louis	190
Schnarr, William	St. Charles	189
Schneider, Paul G.	St. Louis	190
Schneider, Robert J.	St. Louis	190
Schondelmeyer, R. Wade	Columbia	026
Schuessler, Wolfgang P.	St. Louis	190
Schuetz, Alfred	St. Charles	189
Scott, C. Alan	Marshall	198
Scott, Michael R.	Springfield	082
Scott, Robert W.	Springfield	082
Sertl, James F.	St. Louis	190
Shah, Riaz H.	Mexico	014
Shalet, Malcolm F.	Kansas City	125
***Sharp, David G.**	St. Joseph	030
Shatz, Burton A.	St. Louis	190
Shen, Anthony S.	St. Louis	190
Shniter, Lorinna	St. Louis	190
Shuss, David H.	Kansas City	125
Shuttari, Mir F.	St. Louis	190
Sides, Stanley D.	Cape Girardeau	042
Sigmund, Charles J., Jr.	St. Louis	190
Silverstein, Randy B.	St. Louis	190
Sindhwani, Ravinder K.	Louisiana	150
Singh, Kuldeep	Macon	046
Singleton, Charles M., II	Kansas City	125
Sislen, Donald R.	St. Louis	190
Sly, Anne K.	Kansas City	125
Smalling, Ronnie G.	Springfield	082
Smith, Kenneth B.	Washington	074
Smith, Reid C.	Kansas City	125
Smith, Timothy W.	Kansas City	125
Smoller, Martin B.	St. Louis	189
Sneid, David S.	Kansas City	125
Sollars, Eric G.	St. Joseph	030
Sommer, Rand W.	St. Louis	002
Sommer, Ross B.	St. Louis	190
Soonattrakul, Wuthisak	Kennett	070
Sosna, Jacob P.	St. Louis	190
Soucy, John C.	St. Charles	189
Spaedy, Tony	Columbia	026
Spinzig, Bruce D.	Moberly	046
Sprague, Gita	St. Joseph	030
Spurgat, Robert M.	St. Joseph	030
Squitieri, Alphonse J.	St. Louis	190
Stansfield, Julie D.	Columbia	026
Starke, Keith M.	St. Louis	190
***Steinbrecher, Janis M.**	Lee's Summit	125
Sterkel, Barbara B.	St. Louis	190
Sterkel, Richard L.	St. Louis	190
Stewart, James L.	Kansas City	050
Stiene, Henry A.	Joplin	102
Stoffa, Maureen E.	St. Louis	190
Strauss, Carl F.	Kansas City	125
Stuber, Robert R.	St. Joseph	030
Suarez-Solar, Pedro L., Jr.	St. Louis	190
Subramanian, S.	Carthage	102
Sullivan, William W.	St. Louis	190
Suwannasri, Rudee	St. Louis	190
Swaykus, Bernard T.	Bridgeton	190
Sylvanovich, W. Richard	St. Louis	190
Tanphaichitr, Kongsak	St. Louis	190
Tansuwan, Chukiat	St. Louis	190
Tariq, Manzoor A.	Chesterfield	190
Taylor, William K.	Springfield	082
Tepper, Arnold	St. Louis	190
Thesing, John A.	Lenexa, KS	125
Thompson, Randall C.	Shawnee Mission, KS	125
Threlkeld, Kevin L.	Lake St. Louis	002
Thyssen, Erik P.	St. Louis	190
Tilson-Mallett, Nancy R.	Kansas City	125
Titterington, Frank W.	Kansas City	125
Torontow, R. John	Nevada	214
Toubes, Daniel B.	Kansas City	125
Trentham, Orin P., III	Joplin	102
Troeh, Melvin R.	Independence	125
Trotter, W. Yates	Springfield	082
Trygg, Kelly A.	Bolivar	066
Tucker, Leslie E.	Washington	074
Uchiyama, Robert C.	Chesterfield	190
Uhrig, Jack R.	Marshall	198
***Vale, Janett A.**	Kansas City	125
Van Stone, John C.	Columbia	026
Van Goidsenhoven, Guy E.	St. Louis	190
Van Voorn, Catherine M.	Columbia	026
Varma, Devendra K.	Poplar Bluff	034
Vazquez, Jose L.	Florissant	002
***Venter, John L.**	Joplin	102
Ver Dught, Ammon L.	Independence	125
Vibulakaopun, Pairat	BonneTerre	138
***Vogelsang, Judith K.**	Kansas City	125
Vournas, George C.	Bridgeton	190
Wade, Kim C.	Kansas City	125
Wadsworth, Harry L.	St. Louis	190
Wagan, Primitiva C.	St. Louis	190
Waheed, Shahid	Mexico	014
Wald, Stanley M.	St. Louis	190
Walden, James M.	Kansas City	125
Walker, Harvey, Jr.	St. Louis	190
Walker, Melvin O., Jr.	Springfield	082
Walsh, James W.	St. Louis	190
Wantuck, Donald K.	Springfield	082
Webb, Karen B.	St. Louis	190
Weinstock, Leonard B.	St. Louis	190
Weiss, Peter D.	St. Louis	190
Welsh, Thomas E., III	Mexico	014
Welton, Stephen T.	Sikeston	202
Wenneker, Alvin S.	St. Louis	190
Westhoff, David D.	Jefferson City	058
Wethers, Darren E.	St. Louis	190
Weyerich, Noel F.	St. Louis	190
Whitman, Daniel S.	Kansas City	125
Whittaker, Thomas J.	Kansas City	125
Wilkins, Michael S.	Kansas City	125
Williams, R. Jerome, Jr.	St. Louis	190
Wilt, David A.	Kansas City	125
Winer, Nathaniel	Kansas City	125
Winship, Daniel H.	Maywood, IL	002
Wolfe, John E.	Springfield	082
Woodley, Michele C.	St. Louis	190
Woody, Matthew B.	N. Kansas City	125
Woolery, William G.	Sedalia	178
Wright, Jeffrey M.	St. Louis	190
***Wright, Robert A.**	St. Louis	190

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Wright, William P.	St. Louis	190
Wuellner, David H.	Sedalia	178
Wurster, Mark W.	Kansas City	125
Yoxall, Kelly E.	Kansas City	125
Yu, Simon M.	St. Louis	190
Zerr, Charles H.	Independence	125
Zimmerman, Herbert B.	St. Louis	190
Zylka, J. Michael	St. Louis	190

Maternal & Fetal Medicine (MFM)

Amon, Erol	St. Louis	190
Dix, Patricia M.	Springfield	082
Hess, L. Wayne	Columbia	026
Sunderji, Shiraz	St. Louis	190

Neonatal-Perinatal Medicine (NPM)

Braun, William J.	Kansas City	125
Pettett, Gary	Kansas City	125
Slack, Melinda R.	Springfield	082
Thibeault, Donald W.	Kansas City	125
Mosher, Amy A.	St. Louis	190

Nephrology (NEP)

Benson, Larry E.	N. Kansas City	050
Birenboim, Nancy	Kansas City	125
Braxton, Frank W.	Cape Girardeau	042
Dobyan, Dennis C.	St. Joseph	030
Garcia, Stephen E.	Springfield	082
Langley, Harriet .S	Kansas City	125
Mir, A. Rauf	Kansas City	125
Redington, James C.	N. Kansas City	050
Sivarajan, Subramanian	Kansas City	125
Thomas, Alexis G.	Kansas City	125
Winkelmeyer, William K.	Columbia	026

Neurology (N)

Abrams, Bernard M.	Kansas City	125
Adelmann, Eugene	St. Louis	190
Applegate, Clara	West Plains	206
Arkin, Steven M.	Kansas City	125
Arora, Ravinder S.	Sedalia	178
Asher, Irving M.	Columbia	026
Awadalla, Sylvia	St. Louis	190
Batchu, Sudhir S.	Columbia	026
***Belson, Ian L.**	Kansas City	125
Bettinger, Irene E.	Kansas City	125
Bhothinard, Bhisit	Poplar Bluff	034
Black, Joseph T.	St. Louis	190
Bonner, James S.	St. Louis	190
Brownsworth, Ronnie D.	Springfield	082
Choi, Dennis W.	St. Louis	190
Chou, Wesley H.	Overland Park, KS	125
Davuluri, Sreenadha R.	St. Joseph	030
Dean, Philip D.	Washington	074
Desio, Marcus A.	Joplin	102
Dexter, James D.	Columbia	026
Dobmeyer, Susan M.	St. Louis	190
Dysart, Dorsey W., Jr.	Springfield	082
Epstein, Beverly	Mt. Vernon	166
Eyerman, Edward L.	St. Louis	190
Gamboa, Edgardo C.	St. Joseph	030
Geller, Bruce D.	Leawood, KS	125
Hackett, Earl R.	Springfield	082
Hanaway, Joseph	St. Louis	190
Hardin, William B., Jr.	Manchester	190
Hatlelid, J. Michael	St. Louis	190
Hoffmann, Lee M.	Shawnee Mission, KS	125
Hogan, Patrick A.	St. Louis	190
Hooshmand, Ahmad	Jefferson City	058
Horenstein, Simon	St. Louis	190
***Hosley, Brett D.**	Hannibal	150
Lee, David Y.S.	Cape Girardeau	042
Legarda, Maria M.	Kansas City	125
Lin, Chi-Hsi	Springfield	082
Loaiza, Sergio	Sikeston	202
Luzecky, Michael H.	Springfield	082
Makos, Mignon M.	St. Joseph	030
Margolis, Robert P.	St. Louis	190
Matovich, Violet B.	Kansas City	125
McLaren, David L.	Columbia	026
***Mellies, Steven D.**	Cape Girardeau	042
Myers, Gary H.	Chesterfield	190
Otto, Steven M.	Springfield	082
Pentella, Karen J.	St. Louis	190
Phillips, Daniel	St. Louis	190
Quinn, Rodney D.	Springfield	082
Reisler, David M.	Chesterfield	190
Reiss, Jeanne E.	Kansas City	125
Robinson, Jay G.	Kansas City	125
Rosenbaum, Herbert E.	St. Louis	190
Rymer, Marilyn M.	Kansas City	125
Sahota, Pradeep K.	Columbia	026
Schreiber, David J.	Alton, IL	190
Schultz, Earl R.	St. Louis	190
Selhorst, John B.	St. Louis	190
Shakil, Mohammad	Cape Girardeau	042
Sher, Allyn L.	Columbia	026
***Sherrod, Glenn M.**	Bridgeton	190
Shuter, Eli	St. Louis	190
Simowitz, Fredric M.	St. Charles	189
Sohn, Richard	St. Louis	190
***Stahly, Randall L.**	Cape Girardeau	042
***Turpin, F. Duane**	Bridgeton	190
Weinstein, Charles L.	Kansas City	125
Weiss, Howard	St. Louis	190
Weiss, Stuart	St. Louis	190
Winkler, Terry	Springfield	082
Wong, George F., III	Springfield	082
Yanover, Robert A.	St. Charles	190
Yu, Mario K.	Kansas City	125

Neurological Surgery (NS)

Albanna, Faisal J.	St. Louis	190
Backer, Robert J.	St. Louis	190
Bailey, Gregory J.	St. Louis	190
Bernardi, Robert J.	St. Louis	190
Blatt, Geoffrey L.	Kansas City	125
Boland, Michael F.	Chesterfield	190
Bondurant, Charles P.	Columbia	026
Briggs, Thomas B.	Springfield	082
Bucholz, Richard D.	St. Louis	190
Camarata, Paul J.	Kansas City	125
Canlas, Mario P.	Springfield	082
Chaudhari, A. Basit	Cape Girardeau	042
Cheung, K. Charles	Cape Girardeau	042
Chilton, Jonathan D.	Kansas City	125
Colapinto, Edward V.	Columbia	026
Cole, Harry O.	Chesterfield	190
Cova, Reno R.	Cape Girardeau	042
Cox, Curtis S.	Jefferson City	058
Coxe, William S.	St. Louis	190
Crabtree, H. Mark	Springfield	082
Crafts, David	St. Louis	190
Dacey, Ralph G., Jr.	St. Louis	190
Daus, Arthur Steven	Joplin	102
Ditmore, Q. Michael	Columbia	026
Ferguson, John F.	Springfield	082
Gall, Clifford M.	Kansas City	125
Gold, Jonathan A.	St. Louis	190
Goldring, Sidney	St. Louis	190
Greenberg, Jeffrey A.	Joplin	102
Grubb, Robert L., Jr.	St. Louis	190
Hanson, E.J.	Kansas City	125
Hoffman, William F.	St. Louis	190
Hornig, Gregory W.	Kansas City	125
Jacob, Karl A.	St. Louis	190
Jimenez, David F.	Columbia	026

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Kaufman, Andrew B.	125	Kansas City
Kaufman, Bruce A.	190	St. Louis
Kennedy, David G.	190	St. Louis
Kitchens, Daniel L.	190	St. Louis
Krettek, John E.	190	Chesterfield
MacGee, Edwin E.	125	Kansas City
Majzoub, Hish S.	102	Joplin
Marchosky, J. Alex	190	Chesterfield
Martin, Stanley B.	190	St. Charles
Mendelsohn, George E.	190	Chesterfield
Mollman, H. Dennis	190	Chesterfield
Morantz, Robert A.	125	Kansas City
Mujica, Patricio H.	030	St. Joseph
Nichols, Margaret E.	102	Joplin
Oro, John J.	026	Columbia
Orth, O. Gerald	026	Columbia
Park, Bert E.	082	Springfield
Park, Kee B.	042	Cape Girardeau
Picker, Selwyn	190	St. Louis
Pittmann, Thomas	190	St. Louis
Reintjes, Stephen L.	125	Kansas City
Rich, Keith M.	190	St. Louis
***Routsong, Rodney T.**	190	St. Louis
Schoolman, Arnold	125	Kansas City
Scodary, Daniel J.	190	Bridgeton
Sheehan, Paul J.	190	Bridgeton
Silbergeld, Daniel L.	190	St. Louis
Smith, Edward B.	125	Kansas City
Smith, Kenneth R., Jr.	190	St. Louis
Stohr, Paul E.	190	St. Charles
Walker, Francis S.	190	St. Louis
Walker, Gregory E.	125	Independence
Whitlock, C. Courtney	082	Springfield
Wilkinson, David	190	St. Louis
Yoon, Kong-Woo	190	St. Louis
Young, Paul H.	190	St. Louis

Nuclear Medicine (NM)

Allego, Melquiadito M.	174	Perryville
Egbert, Robert N.	082	Springfield
Ho, Judith E.	190	St. Louis
Long, Stephen E.	082	Springfield
Siegel, Barry A.	190	St. Louis

Nuclear Radiology (NR)

Mosher, Amy	190	St. Louis

Obstetrics & Gynecology (OBG)

Adams, Kenneth A.	125	Independence
Ahlum, Sandra J.	150	Hannibal
Ahmad, Nusrat J.	190	Chesterfield
Albracht, Renee M.	215	St. Louis
Anstey, John T.	190	St. Ann
Appelbaum, John K.	002	St. Louis
Arendt, Kathryn L.	190	St. Louis
Arias, Fernando	190	St. Louis
Azan, Abraham N.	178	Sedalia
Bagwe, Lata R.	190	St. Louis
Bale, Robert D.	190	St. Louis
Batts, Barbara A.	125	Kansas City
Baumann, Daniel J.	190	St. Louis
Beaty, William R.	190	St. Ann
Becker, Robert L.	190	St. Louis
Beckmann, Charles R.B.	125	Overland Park, KS
Beguin, Everett A., Jr.	082	Springfield
Behrend-Uhls, Ann E.	042	Cape Girardeau
Bell, Laird A.	082	Springfield
Benitez, Jose A.	190	St. Louis
Benson, Ronald G.	082	Springfield
Benton, Mary Beth	026	Columbia
Bever, Grant A.	190	St. Louis
Blaskiewicz, Robert J.	190	St. Louis
Blythe, James G.	190	St. Louis
Boedeker, James P.	190	St. Louis
***Boice, Brett E.**	102	Joplin
Boice, Michelle A.	102	Joplin
Bonebrake, Albert J.	082	Springfield
Bonebrake, Mac D.	082	Springfield
Borello, Dan J.	102	Joplin
Botney, Kathryn	190	St. Louis
Boveri, Lawrence V.	002	St. Louis
Boyd, Craig W.	190	St. Louis
Braby, Howard H.	125	Independence
Brady, Jane R.	190	St. Louis
Brennan, James M.	190	St. Louis
Brennan, Robert A., Jr.	190	St. Louis
Brown, Cynthia L.	034	Poplar Bluff
Brown, Robert J.	189	St. Charles
Bruno, Patrick L.	150	Hannibal
Burks, Michael L.	026	Columbia
Burstein, Robert	190	St. Louis
Caffrey, Robert T.	125	Independence
Camejo, Manuel	082	Springfield
Cannon, Jenifer M.	190	St. Louis
Caputo, Cynthia J.	125	Raytown
Cargill, Dianna L.	050	Liberty
Caruso, Peter J.	125	Kansas City
Casey, Arthur L.	190	St. Louis
Cernik, Christine C.	190	St. Louis
Chesney, John W.	102	Joplin
Chirino, Octavio R.	190	St. Louis
Chod, Ronald J.	190	St. Louis
Clark, Larry K.	102	Joplin
Clarke, Paul W.	042	Cape Girardeau
Comas, Manuel R.	190	St. Louis
Cooper, Robert L., II	110	Warrensburg
Coordes, Kathleen M.	190	St. Louis
Corder, Robert L.	030	St. Joseph
Cornwell, Karen R.	125	Kansas City
Covarrubias, Jorge A.	190	Phoenix, AZ
Cox, Jeffrey L.	102	Joplin
Coyne, Patrick M.	190	Bridgeton
Crane, James P.	190	St. Louis
Dagartzikas, A.K.	190	St. Louis
Dahm, Charles H., Jr.	190	St. Louis
Davidson, Raymond P.	190	St. Louis
Davis, Cynthia L.	150	Hannibal
Del Pizzo, Ferdinand	189	St. Charles
Dement, Oman E.	102	Joplin
DeRosa, Michael J.	190	St. Louis
DeUngria, Pablo C.	190	Bridgeton
Dieterich, Russell B.	189	St. Charles
Doan, Laura B.	125	Raytown
Driskell, Karen K.	125	Kansas City
Duduzinski, Michelle	125	Kansas City
Dunlap, Patrick S.	102	Joplin
Durel, Justin H.	190	St. Louis
Eachempati, Uma R.	190	Arnold
Eaton, Paula	125	Kansas City
Ekunno, Josiah O.	190	St. Louis
Fast, Robert E.	030	St. Joseph
Ferber, Alan J.	125	Kansas City
Ferns, Francis E.	125	Kansas City
Fitts, Bill	214	Nevada
Fleer, Gerald K.	189	St. Peters
Fogle, Philip R.	082	Springfield
Fortin, Jorge A.	135	Rolla
Friesen, Randall G.	189	St. Charles
Gall, Ira C.	190	St. Louis
Gardner, Joe A.	102	Joplin
Garrard, Jacqueline M.	190	St. Louis
Garrison, David L.	030	St. Joseph
Gay, John W.	026	Columbia
Gimpelson, Richard J.	190	Chesterfield

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OBSTETRICS & GYNECOLOGY

Goeking, C. Keith St. Joseph	030
Goldman, Gordon M. St. Louis	190
Grant, Laura L. Columbia	026
Grant, Mark Columbia	026
Gray, Scott E. Springfield	082
Grechus, John J. Farmington	138
Green, Thomas F. Independence	125
***Greenspan, Peter B.** Independence	125
Griffin, William T. Columbia	026
Grimm, Mary T. Florissant	190
Gulick, C. Richard St. Louis	190
Gutknecht, Richard Independence	125
Hahn, Yoram Florissant	190
Halberstadt, Cathanie W. Kansas City	125
Handler, Michael R. St. Louis	190
Hanley, Thomas P. St. Louis	190
Hartman, Richard A. St. Louis	190
Haskins, Robert D., Jr. Springfield	082
Hauser, Robert J. Jefferson City	058
Hayes, Kimberly W. Lee's Summit	125
Hazan, Joseph Bridgeton	190
Heller, Randall L., Jr. St. Louis	190
Herzog, Godofredo M. Florissant	190
Hickey, James L. St. Louis	190
Higginbotham, Dennis G. West Plains	206
Hill, Randy C. Springfield	082
Hoja, John M. Poplar Bluff	034
Hoja, W. Alex Poplar Bluff	034
Houck, William E. Chesterfield	190
Hubbell, George P. Osage Beach	120
Hulbert, Laura R. St. Louis	190
Hunleth, Frank E. St. Louis	190
Huse, William J., II Kansas City	125
Huster, Robert M. Liberty	135
Ishida, Yasuo St. Louis	190
Jantsch, Deborah A. Kansas City	125
Jessup, Michael J. Cape Girardeau	042
Jewell, Gregory L. St. Louis	190
Johar, Ravi S. St. Louis	190
Johnson, Joseph C., Jr. Springfield	082
Johnson, Rebecca S. Kansas City	125
Jones, Jeffrey T. Joplin	102
Jones, Michael D. Mexico	014
Kelly, John B. Joplin	102
Kim, Yang H. Washington	074
Kline, James St. Joseph	030
Kobbermann, Kobby J. Springfield	082
Kratz, Donald P. Springfield	082
Kuebel, Richard J. St. Louis	190
Kumari, Vijaya St. Louis	190
Kunda, Koteswara R. St. Louis	190
Lacey, Hugh L. Joplin	102
Ladd, Christine M. St. Louis	190
Lamping, J. Daniels St. Louis	190
***Lentz, Rodney D.** Jefferson City	058
Levy, Edward S. St. Louis	002
Lin, C.H. Moberly	046
Lintecum, Frederick B. Kansas City	125
Liu, Ben C. Kansas City	125
Lockwood, Gary F. Kansas City	125
Madduri, Aruna D. Poplar Bluff	034
Magaletta, George E. St. Louis	002
***Magill, William S.** Springfield	082
Maitz, Carlos A. St. Ann	190
Mani, Mary E. St. Louis	190
Marshall, William H. Jefferson City	058
Marston, F. James St. Joseph	030
Martin, Daniel J., Sr. St. Louis	190
Mathew, Ruby Chesterfield	190
Matile, Gerald U. Kansas City	125
Maupin, Kathy C. Florissant	190
Maxson, Katherine A. Chesterfield	190
Maynard, Colleen M. Kansas City	125
McCorcle, Marcus D. Springfield	082
McDavid, Robert E. Columbia	026
McKeown, Robert A. Bucyrus	206
McLaughlin, Richard D. Springfield	082
Medler, John F. St. Louis	190
Meiners, Theodore M. Chesterfield	190
Middleton, Jerry N. Chesterfield	190
Miller, Gerald L., Jr. Kansas City	125
Mistry, Tehmton S. Columbia, IL	190
Moeller, F. Delbert Lake St. Louis	189
Monterubio, Fred R., Jr. St. Louis	190
Mooney-Smith, Patricia Kansas City	125
Moreton, David W. Columbia	026
Morley, Mary A. Chesterfield	190
Morris, Terry V. Independence	125
Mou, Susan M. Kansas City	125
Muckerman, Richard C., II St. Louis	190
Mueller, Cynthia J. St. Louis	002
Mundy, David C. Kansas City	125
Murdock, Nathaniel St. Louis	190
Nagy, Rickey E. Kansas City	125
Newport, Gerald Florissant	190
Nickell, Margaret B. Kansas City	125
Nouri, Hassan St. Louis	190
Ojascastro, Lou St. Louis	190
Ong, Ofelia S. St. Louis	190
Ostapowicz, Tamara L. St. Louis	190
Ott, Harold J., II St. Louis	190
Ott, William J. St. Louis	190
Otto, William J. Springfield	082
Ottolini, James L. Chesterfield	190
Padilla, Teresita C. Chesterfield	190
***Palmer, Allen S.** Bridgeton	190
Paraiso, Marie F. Kansas City	125
Patty, Carl F. Poplar Bluff	034
***Patty, John R.** Poplar Bluff	034
Pearce, Eugene W.J. Kansas City	125
Pearman, Carl C. Kansas City	002
Pearse, CarltonS. Chesterfield	190
Pearson, William E. St. Louis	190
Perryman, Douglas R. Kansas City	125
Phillips, Granville J. Warrensburg	110
Pignotti, Blase J. St. Louis	190
Poole, Anthony G. Sikeston	202
Potts, Gregory A. Washington	074
Powell, Lisa G. Springfield	082
Pringle, Scot G. Cape Girardeau	042
Pryor, Carolyn J. Florissant	190
Puckett, Lynn M. Columbia	026
Pyeatte, Jacob P., Jr. Cape Girardeau	042
Radley, Anne M. Florissant	190
Rajcher, Wilma J. Columbia	026
Rappold, Henry O. Chesterfield	002
Redfern, David L. Springfield	082
Reed, Jonathan R. St. Louis	190
Rengachary, Dhanalakshmi Kansas City	125
Rice, Lee Roy Joplin	102
Rice, Valerie M. Kansas City, KS	050
Richardson, Curtis J. St. Joseph	030
Roberts, Christopher H. Joplin	102
Robinson, Gary L. Springfield	082
Rosenbaum, Jessica St. Louis	215
Sachar, Jerome D. St. Louis	190
Saha, Sudha R. St. Louis	190
Schaberg, Kevin B. Chesterfield	190
Schuetz, Evelyne G. St. Charles	189
Schwartz, Howard I. Kansas City	125
Seeck, Linda E. Washington	074
Shaner, Thomas P. St. Louis	190
Shelton, Becky R. Chesterfield	190
Shultz, Thomas M. Springfield	082
Shuman, Mary Mission, KS	215
Siripipat, Pallop Mexico	014
Smiley, William L. St. Louis	190
Smith, Brenda S. Kansas City	125

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Snidle, William F. Crystal City	106
Snowden, Kent L. St. Louis	190
Sopuch, John A. St. Louis	190
Stamps, Gregory S. Springfield	082
Steiman, Barry St. Charles	189
Stockwood, Robert C. Sedalia	178
Streiff, Maria G. St. Louis	190
Strobach, Kurt F. St. Louis	190
Stuppy, Mark S. Springfield	082
Su, Philo S. Jefferson City	058
Sullivan, Bradley H. Kansas City	125
Tackitt, Bobby O., II Poplar Bluff	034
Tegeler, Kent E. Liberty	050
Tendai, Mark M. Springfield	082
Thomas, Jonathan L. Cape Girardeau	042
Thompson, M. Bryant Chesterfield	190
Thomure, Michael F. St. Louis	002
Thornton, Michael K. St. Peters	106
Tobey, Albro C., Jr. St. Louis	190
Tobler, Randall W. St. Louis	190
Trammell, Lee W. Columbia	026
Treacy, Bryan J. Bolivar	066
Triplett, Daniel A. Liberty	050
Trumbower, William D. Columbia	026
Turano, William L. Raytown	125
Vajaranant, Manit Lexington	118
Van Dyke, Elmer H. Sedalia	178
Villamar, Elizabeth N. St. Louis	190
Vivian, Gary D. St. Peters	189
Wagner, Daniel G. St. Louis	190
Walker, Gary K. Springfield	082
Walker, J. Leslie St. Louis	190
Wallace, Darryl L. Kansas City	125
Walley, Lynn J. Hannibal	150
Walsh, Barbara A. St. Louis	190
Wasserman, Mark S. St. Louis	190
Weinstein, David L. St. Louis	190
Wheeler, Paul D. Liberty	050
White, Eugene F. Rolla	135
Whitten, J. Stephen Cape Girardeau	042
Wilbois, Ronald P. St. Louis	190
Williams, Fred Columbia	026
Williams, John W., IV Springfield	082
Wolaniuk, Anna C. St. Charles	190
Womack, Stephanie E. Columbia	026
Wright, Andy J. Springfield	082
Yahnke, David G. Farmington	138
Yang, John S. Ste. Genevieve	174
Yeast, John D. Kansas City	125
Yoon, Jin S. Chillicothe	078
Youngblood, James P. Kansas City	125

Occupational Medicine (OM)

Armbruster, A.A. Stilwell, KS	002
Baker, John H. Creve Coeur	190
Beeks, John W. Kansas City	125
Belz, Norbert T. Springfield	082
Black, William R. Neosho	102
Bogner, Stuart M. St. Louis	190
Bono, Gregory L. Lenexa, KS	125
***Bynum, Carl G.** Jefferson City	058
***Cooper, Glen E.** Columbia	026
Kopp, Shelby K. St. Louis	190
Meadows, C. Douglas St. Louis	190
Paff, David G. Springfield	082
Patel, Ashokkumar B. St. Louis	190
Stenberg, Michael D. Dubuque, IA	050
Vale, Janie R. Columbia	026

Oncology (ON)

Carolla, Robert L. Springfield	082
Coe, Tracy L. Joplin	102
Croy, David W. Joplin	102
Cunningham, William F. Springfield	082
Fleming, Allan R. Kansas City	125
Hanson, Karl H. Kansas City	125
Honeycutt, Pamela J. Columbia	026
Hoos, Gary L. Springfield	082
Janney, Stephen K. St. Louis	190
Khojasteh, Ali Columbia	026
LaFrancis, Irving E. Joplin	102
Luedke, Susan L. St. Louis	190
Matthews, Richard H. Rolla	135
Morris, R. William St. Louis	190
Myron, Mark C. Kansas City	125
Ota, David M. Columbia	026
Perry, Michael C. Columbia	026
Picus, Joel St. Louis	002
Schlossman, David M. Columbia	026
Schultz, Paul K. St. Louis	190
Skelley, Mark J. Joplin	102
Stephenson, William T. Kansas City	125
***Stillie, G. Donald** Kansas City	125
Van Amburg, Albert L., III Chesterfield	190
Wilkes, John D. Columbia	026
Yuen, Benjamin H. Cape Girardeau	042

Ophthalmology (OPH)

Altenbernd, Todd W. Cape Girardeau	042
Amin, Navin J. St. Louis	190
Arnold, Paul N. Springfield	082
Avins, Laurence R. St. Louis	190
Barnes, Charles H. Kansas City	125
Bass, Walter R. Prairie Village, KS	125
Bauman, Alan E. Kansas City	125
Becker, Bernard St. Louis	190
Becker, Stanley C. St. Louis	190
Becker, William L. St. Louis	190
Benedett, Robert E. Springfield	082
Berdy, Gregg J. St. Louis	190
Berg, Edward F. Chesterfield	190
Blair, Jerry R. Columbia	026
Bohigian, George M. St. Louis	190
Bonham, Roger D. Columbia	026
Boniuk, Isaac St. Louis	190
Bowen, Stephen F., Jr. St. Louis	190
Brady, Harry R. St. Louis	190
Brigham, David W. Ballwin	190
Bruce, Leo A. Sikeston	202
Burgess, Dean St. Louis	190
Byars, Steven R. Kansas City	125
Canaan, Samuel A., Jr. St. Louis	190
Carney, Susan M. Kansas City	050
Case, William F. Kansas City	125
Catanzaro, Frank J., Jr. St. Louis	190
Chipongian, Raul A. St. Louis	190
Chishti, M. Ishaq St. Louis	190
Chu, Fred C. Chesterfield	190
Chung, Sophia M. St. Louis	190
Cibis, Gerhard W. Kansas City	125
Clever, Victor G. St. Charles	189
Cokingtin, Cliff Overland Park, KS	125
Cowden, John W. Columbia	026
Cox, Mark T. Sedalia	178
Cozean, Charles H. Cape Girardeau	042
***Crane, William** St. Joseph	030
Cundiff, H. Clay Independence	125
Curran, Terrence Kansas City	125
Dehning, Doug O. Independence	125
Del Priore, Lucian V. St. Louis	002
Deligeorges, John Kansas City	002
Doane, John F. Independence	125
Durrie, Daniel S. Kansas City	125
Dyer, David S. Kansas City	125
Eggleston, Harry C. St. Louis	190

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OPHTHALMOLOGY

Eggleston, Thomas F.	**190**	St. Louis
Ellis, Jean H.	**125**	Blue Springs
Escoffery, Richard F.	**190**	Florissant
Faulkner, C. Byron	**082**	Springfield
Fischer, Heidi	**150**	Hannibal
Fitz, John R.	**138**	Farmington
Floerchinger, James S.	**002**	St. Louis
Ford, Thomas E.	**190**	NiagaraFalls, NY
Gabel, Michael G.	**190**	St. Louis
Gans, Lawrence A.	**190**	Florissant
Gessler, James A.	**082**	Springfield
Giangiacomo, Joseph	**026**	Columbia
Gigantelli, James W.	**026**	Columbia
Goldstein, Marvin F.	**125**	Kansas City
Goltschman, John P.	**190**	Florissant
Goodrich, Steven D.	**190**	Florissant
Gordon, James M.	**190**	Florissant
Grand, M. Gilbert	**190**	St. Louis
Green, Morton R.	**190**	Belleville, IL
Hagan, John C., III	**050**	N. Kansas City
Hainsworth, Dean P.	**026**	Columbia
Hart, William M., Jr.	**190**	St. Louis
Hartstein, Jack	**190**	Chesterfield
Hembree, Kathryn A.	**050**	Liberty
Hinshaw, Kevin D.	**190**	St. Louis
Holds, John B.	**190**	St. Louis
Holekamp, Timothy	**026**	Columbia
Honickman, Neal A.	**042**	Cape Girardeau
Horton, Bill G.	**082**	Springfield
Hunkeler, John D.	**125**	Kansas City
Hyde, Lawrence L.	**125**	Kansas City
Johnson, Cindi K.	**030**	St. Joseph
Johnson, Lenworth N.	**026**	Columbia
Jones, Robert W.	**206**	West Plains
***Jordan, Earl L., Jr.**	**102**	Joplin
Jung, J. Marshall	**042**	Cape Girardeau
Kamenetzky, Stephen A.	**190**	St. Louis
Kaplan, Henry J.	**190**	St. Louis
Kapp, Mary Beth	**042**	Cape Girardeau
Kass, Michael A.	**190**	St. Louis
Kayes, Jack	**190**	St. Louis
Keithahn, Mari A.Z.	**026**	Columbia
Kenneally, Cynthia Z.	**190**	St. Louis
Khatana, Anup K.	**125**	PrairieVillage, KS
Kies, Richard L.	**042**	Cape Girardeau
Knopf, Harry L.	**190**	St. Louis
Koenig, Marvin I.	**190**	St. Louis
Kolker, Allan E.	**190**	St. Louis
Korenfeld, Michael S.	**074**	Washington
Kretchmar, Alan P.	**190**	St. Louis
Krummenacher, Thomas K.	**190**	St. Louis
Lederer, Charles M., Jr.	**125**	Kansas City
Lee, King Y.	**125**	Shawnee Mission, KS
Lee, Steven F.	**002**	St. Louis
Leibsohn, Joel M.	**125**	Independence
Lentz, KathyJ.	**074**	Washington
Levenson, Ernest	**034**	Poplar Bluff
Levy, Donald S.	**189**	St. Charles
Lewis, Matthew T.	**058**	Jefferson City
Lewis, Robert D.	**190**	St. Louis
Linde, John W.	**135**	Rolla
Lubniewski, Anthony J.	**190**	St. Louis
Luetkemeyer, James G.	**058**	Jefferson City
***Lumsden, Todd J.**	**042**	Cape Girardeau
Lyon, David B.	**125**	PrairieVillage, KS
Matta, Camille S.	**125**	Kansas City
Mattax, James B., Jr.	**082**	Springfield
McCabe, Eugene J.	**189**	St. Charles
McKnight, Scott J.	**050**	Liberty
McLaughlin, Durnell	**125**	Kansas City
Mehlhorn, Gary L.	**082**	Springfield
Michaels, Robert H.	**082**	Springfield
Milder, Barry D.	**190**	St. Louis
Miller, James E.	**190**	St. Louis
Morey, Kirk P.	**190**	St. Louis
Morgan, Stephan S.	**190**	St. Louis
Morrison, Tom V.	**208**	Branson
Murphy, James A.	**030**	St. Joseph
Neu, Kenneth W.	**082**	Springfield
Neu, Leo T., III	**082**	Springfield
Newman, Matthew	**190**	St. Louis
O'Donnell, Francis E.	**190**	St. Louis
Olk, R. Joseph	**002**	Chesterfield
Ott, F. Thomas	**190**	St. Louis
Parelman, Allen G.	**125**	Kansas City
Pepose, Jay S.	**002**	St. Louis
Perlmutter, John C.	**189**	St. Charles
Pernoud, Flavius G., III	**190**	St. Louis
Pernoud, Joan M.	**190**	St. Louis
Peterson, Craig A.	**082**	Springfield
Piebenga, Larry W.	**125**	Kansas City
Plowman, Edward M.	**150**	Hannibal
Pojanasomboon, Pichat	**135**	Rolla
Poulose, Abraham K.	**125**	Prairie Village, KS
Prater, Thomas G.	**082**	Springfield
Price, Patrick K.	**125**	Shawnee Mission, KS
Purcell, John J., Jr.	**190**	St. Louis
Rahman, Moudur	**190**	Chesterfield
Reddy, Nalini A.	**206**	West Plains
Rednam, Krishnarao V.	**190**	St. Louis
Ridgeway, William G.	**190**	St. Louis
Rieger, Frank G.	**026**	Columbia
Ringer, C. Nelson	**042**	Cape Girardeau
Robinson, James C.	**026**	Columbia
Rogers, Casey	**014**	Mexico
Rosenthal, William N.	**125**	Kansas City
Sabates, Felix N., Sr.	**125**	PrairieVillage, KS
Sabates, Nelson R.	**125**	PrairieVillage, KS
Sabates, Roland	**125**	Kansas City
Samudrala, Ramulu	**190**	St. Louis
Schanzlin, David J.	**190**	La Jolla, CA
Schoch, Lawrence H.	**190**	Florissant
Schoengarth, Lowell D.	**026**	Columbia
Schrenk, Loren C.	**190**	St. Louis
Scott, Wendell J.	**082**	Springfield
Shah, Ramesh R.	**102**	Joplin
Shelton, R. Wayne	**082**	Springfield
Short, Howard N.	**074**	Washington
Siegfried, Carla J.	**190**	Ballwin
Sigmund, Charles A.	**190**	Bridgeton
Silver, Bernd	**190**	St. Louis
Silverstein, Steven M.	**125**	Kansas City
Slocum, Stephen G.	**190**	St. Louis
Smith, Carol A.	**215**	St. Louis
Smith, Porter	**070**	Poplar Bluff
Song, James	**215**	Chesterfield
Spurrier, Mark H.	**190**	St. Louis
Stafford, Walter R.	**190**	St. Louis
Stauffer, Larry K.	**058**	Jefferson City
Steinvurzel, Mark D.	**215**	St. Louis
Stewart, L. Paul	**190**	St. Louis
Stiles, Michael C.	**125**	Kansas City
Stout, Carl N.	**125**	Independence
Taylor, John R.W.	**125**	Independence
Tekwani, Hiralal T.	**190**	St. Louis
Tess, Allen F.	**190**	Florissant
Thomas, Matthew A.	**190**	St. Louis
Tobin, Robert F.	**030**	St. Joseph
Traxel, William L.	**034**	Poplar Bluff
Tsai, Linda	**215**	St. Louis
Tyler, Thomas D.	**118**	Richmond
Unwin, Donald R.	**190**	St. Louis
Wankum, Robert P.	**058**	Jefferson City
Watson, Richard A.	**030**	St. Joseph
Wax, Martin B.	**190**	St. Louis
Weir, Robert K.	**125**	Kansas City
Westrich, David J.	**042**	Cape Girardeau
Wexler, Stephen A.	**190**	St. Louis

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*Doctor of Osteopathy

Whitacre, Marc M.	125	Prairie Village, KS
White, William L.	125	Kansas City
Wiles, Stephen B.	125	Kansas City
Wills, Theodore E.	026	Columbia
Wolf, Mitchel L.	190	St. Louis
Wurster, Jerry B.	125	Prairie Village, KS
Yang, H. Kell	026	Columbia
Young, Thomas J.	030	St. Joseph
Ziemianski, Matthew C.	125	Kansas City

Orthopedic Surgery (ORS)

Abernathie, Dennis L.	026	Columbia
Adams, Allen G.	190	St. Louis
Adams, Mark A.	026	Columbia
Adler, Federico	125	Kansas City
Alander, Dirk H.	125	Kansas City
Albus, Thomas E.	190	Bridgeton
Allen, William C.	026	Columbia
Anderson, David J.	190	St. Louis
Anglen, Jeffrey O.	026	Columbia
Aubuchon, Craig E.	190	St. Louis
Baldwin, Richard, Jr.	190	St. Louis
Ball, David A.	102	Joplin
Barnthouse, Cris D.	125	Kansas City
Bassman, Donald R.	190	St. Louis
Beall, McPherson S., Jr.	125	Kansas City
Beckett, Wm. Wilson	026	Columbia
Belew, Mark	190	Florissant
Benson, William F.	125	Kansas City
Bernhardt, Mark	125	Kansas City
Bieniek, Christopher M.	150	Hannibal
Black, David L.	102	Joplin
Blair, Vilray P., III	190	St. Louis
Bliss, Greg A.	125	Blue Springs
Bohn, William W.	125	Kansas City
Bonar, Susan K.	125	Kansas City
Boylan, Peter C.	125	Kansas City
Bradbury, George R., III	190	Bridgeton
Brancato, Donald H.	190	St. Louis
Brennan, Richard J.	030	St. Joseph
Britt, Cornelius L.	106	Crystal City
Brown, David W.	082	Springfield
Browne, Jon E.	125	Kansas City
Bruce, Robert P.	125	Kansas City
Buchert, Peter K.	026	Columbia
Burdge, Robert E.	190	St. Louis
Burke, James S., Jr.	190	St. Louis
Burleigh, Bruce W.	102	Joplin
Burns, Michael F.	190	St. Louis
Burton, Curtis D.	150	Hannibal
***Cameron, Roger W.**	058	Jefferson City
Carter, Edwin E.	190	St. Louis
Chalk, David E.	074	Washington
Cho, Kyu S.	190	St. Louis
Clarke, Michael S.	082	Springfield
Clothiaux, Pierre L.	082	Springfield
Corcoran, Michael J.	026	Birmingham, AL
Cordell, Larry D.	125	Kansas City
Couchman, Ryan W.	190	St. Louis
Cunningham, R. Raymond	026	Columbia
Curnow, Richard B.	050	Liberty
Darnell, Dale E.	125	Kansas City
Davis, Leonard L.	014	Columbia
DiFilippo, Emil A.	189	St. Charles
Doerr, Dale E.	190	St. Louis
Downs, Daniel M.	125	Kansas City
Drisko, Robert M., II	125	Kansas City
Dugan, Gerald F.	125	Kansas City
Duncan, Douglas M.	082	Springfield
Dusek, Dennis A.	190	St. Louis
Eckenrode, James F.	026	Columbia
Edwards, Ryan K.	178	Sedalia
***Ellefsen, Brian K.**	102	Carthage
Eller, Gordon W.	042	Cape Girardeau
Ellfeldt, Howard J.	125	Kansas City
Ellsasser, James C.	026	Rocheport
Emanuel, James P.	190	St. Louis
Esch, John G.	102	Joplin
Evans, Lawrence G., Jr.	190	St. Louis
***Farley, Gary W.**	190	St. Louis
Fox, Thomas J.	190	St. Louis
Frank, Gael R.	125	N. Kansas City
Frevert, Larry F.	125	Kansas City
Frewin, Paul R.	082	Springfield
Frumson, Guy H.	190	Florissant
Gaines, Robert W.	026	Columbia
Gainor, Barry J.	026	Columbia
Galakatos, Gregory R.	190	St. Louis
Gardiner, Robert C.	125	Kansas City
Garner, James H.	125	Kansas City
Gelberman, Richard H.	190	St. Louis
Gilden, Jerome J.	190	St. Louis
Glaser, Larry F.	125	Cleveland
Goldfarb, Charles	215	St. Louis
Gondring, William H.	030	St. Joseph
***Graven, Timothy G.**	106	DeSoto
Greene, Walter B.	026	Columbia
Grillot, Michael B.	082	Springfield
Gunter, Kevin G.	178	Sedalia
Gurba, Danny M.	125	Kansas City
Haas, Robert W.	050	Liberty
Hagan, Phillip F.	050	Liberty
Hammond, D. Wade	190	St. Louis
Harmon, Ben C.	082	Springfield
Harris, Hugh G.	082	Springfield
Harris, Lanny W.	125	Kansas City
Haupt, Herbert A.	190	St. Louis
Havey, John	026	Columbia
Healy, Brian E.	002	Kansas City
Hernandez, Salvador R.	190	St. Louis
Highland, Thomas R.	026	Columbia
Holand, Roy W.	082	Springfield
Hollocher, Richard J.	190	St. Louis
Holt, Benjamin T.	026	Columbia
Hummel, Gregory L.	125	Independence
Humphreys, William	030	St. Joseph
***Hunter, Harlen C.**	190	Chesterfield
Jackson, Roger P.	050	Kansas City
Jarka, Dale E.	125	Kansas City
Jeffries, Joel T.	026	Columbia
Johnson, Glen E.	190	St. Louis
Johnston, Richard	190	St. Louis
Jolly, Ben L.	014	Mexico
Jones, Bruce N.	190	Chesterfield
Jones, Lowry, Jr.	125	Kansas City
Jones, Robert P.	125	Blue Springs
Joyce, Steven T.	125	Kansas City
Kapp, William K., III	042	Cape Girardeau
Kefalas, John C.	074	Washington
Kenney, John D.	002	St. Louis
Keohane, Mark	189	St. Charles
Kiburz, Douglas W.	178	Sedalia
Koch, F. Daniel	125	Kansas City
Kramer, Robert S.	190	St. Louis
Krautmann, John J.	058	Jefferson City
Kriegshauser, Lawrence A.	190	St. Louis
Lange, David R.	190	Bridgeton
Lee, Thomas K.	190	St. Louis
Lehman, Richard C.	190	St. Louis
Lents, Rickey L.	042	Cape Girardeau
Leslie, James T.	058	Jefferson City
Linsenmeyer, Charles M.	189	St. Charles
Lintecum, Neal D.	125	Kansas City
Littlejohn, Robert T.	050	N. Kansas City
Lord, Richard E.	190	St. Louis
Luechtefeld, Frank	190	Florissant
Luther, George A.	190	St. Louis

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*Doctor of Osteopathy

Mahnken, Robert F.	082	Springfield
Mannis, Charles I.	190	St. Louis
Manske, Paul R.	190	St. Louis
Marshall, Michael P.	002	Kansas City
Marti, Larry B.	135	Rolla
Martin, Daniel J., Jr.	190	St. Louis
Martin, Jeffrey W.	190	St. Louis
Matava, Matthew	190	St. Louis
Matthews, Thomas D.	074	Washington
Maylack, Fallon H.	190	Florissant
McAllister, John W., II	189	St. Peters
McClain, Thomas D.	082	Springfield
McMillin, John N.	082	Springfield
McMullin, Forbes A.	190	St. Louis
McNamara, Gerald R.	125	Kansas City
Mell, Roger L.	190	Chesterfield
Merenda, Frank J.	190	St. Louis
Merenda, James T.	190	St. Louis
Merkel, Kurt D.	190	St. Louis
Miller, Harry G.	086	Clinton
Mirbaha, Mitchell M.	190	St. Louis
Morris, Alan H.	190	St. Louis
Nachtigal, Michael P.	082	Springfield
Nashed, Rafat S.	190	St. Louis
Neighbor, Ernest H.	125	Kansas City
Newland, Craig C.	002	Liberty
Nogalski, Michael P.	190	St. Louis
Olive, Paul M.	082	Springfield
***Page, Lawrence V.**	102	Joplin
Park, Thomas	215	Columbia
Parkins, George K.	125	Kansas City
Parsons, Clyde W., III	082	Springfield
Pawsat, John E.	125	Kansas City
Pearson, Richard L.	174	Ste. Genevieve
Petkovich, Frank O.	190	St. Louis
Phillips, John J.	190	Florissant
Phillips, Thomas P.	125	Kansas City
Piontek, Jerome G.	190	Chesterfield
Piper, Terrence L.	189	St. Charles
Pomphrey, Martin M., Jr.	190	Chesterfield
Price, Nigel, J.	125	Kansas City
Putnam, John L.	082	Springfield
Reardon, James P.	050	N. Kansas City
Reeves, R. Bradley	102	Joplin
Rhoades, Charles E.	125	Kansas City
Rich, Margaret M.	190	St. Louis
Rispler, David T.	058	Jefferson City
Ritter, R. August, III	042	Cape Girardeau
Ritter, Ray A., Jr.	042	Cape Girardeau
Rodgers, W. Blake	058	Jefferson City
Rogers, David B.	082	Springfield
Rose, Barry A.	125	Overland Park, KS
Rosenthal, Howard G.	125	Kansas City
Roush, Randall D.	190	Florissant
Ryan, Thomas J.	058	Jefferson City
Samson, Barry L.	190	St. Louis
Samuelson, Thomas S.	125	Kansas City
Sanchez, Jon J.	082	Springfield
Sandow, Theodore L.	125	Kansas City
Satterlee, C. Craig	125	Kansas City
Schaberg, James E.	189	St. Charles
Schlafly, Bruce S.	190	St. Louis
Schlafly, Edward F., Jr.	190	Chesterfield
Schmidt, Thomas L.	125	Kansas City
Schoedinger, George R., III	190	St. Louis
Schoenecker, Perry L.	190	St. Louis
Schroer, William C.	002	Bridgeton
Schwarze, Daniel J.	190	St. Louis
Sciortino, Robert A.	190	Bridgeton
Scott, Andrew	125	Kansas City
Seagrave, Richard A.	082	Springfield
Sedgwick, William G.	190	St. Louis
Sertl, George O.	190	St. Louis
Shaeffer, James T.	082	Springfield
Shaffer, William O.	190	St. Louis
Sheridan, John J.	190	St. Louis
Shitut, Ravindra V.	190	St. Louis
Shively, Robert A.	190	St. Louis
Sicat, Alfonso V.	110	Warrensburg
Skimming, W. Lee	190	St. Louis
Smith, Bruce D.	030	St. Joseph
***Smith, C. Daniel**	030	St. Joseph
Smith, Kenneth R.	206	Bolivar
Smith, Patrick A.	026	Columbia
Stetson, William B.	190	St. Louis
Stokes, Douglas L.	030	St. Joseph
Strecker, William B.	190	St. Louis
Strickland, James C.	190	St. Louis
***Stringer, Robert F.**	102	Joplin
Strong, Alexandra J.	125	Kansas City
Stronsky, David	190	St. Louis
Sudekum, Joseph M.	190	St. Louis
Sundstrom, Frank D.	082	Springfield
Susi, Jesse G.	190	St. Louis
Sutherland, Charles J.	190	Ottawa Hills, OH
Swaim, Truett	125	Blue Springs
Swango, J. Scott	082	Springfield
Takacs, Robert J.	125	Kansas City
Tessier, John E.	190	St. Louis
Thomas, Leslie D.	050	N. Kansas City
Thorpe, William P.	042	Cape Girardeau
Tillema, David A.	125	Kansas City
Trecha, Randal R.	026	Columbia
True, John H.	034	Poplar Bluff
Trueblood, Michael C.	042	Cape Girardeau
Tucker, Robert E.	190	St. Louis
Tupper, Joel	102	Joplin
Turnbaugh, Thomas R.	058	Jefferson City
Turner, Michael L.	034	Poplar Bluff
Van Ryn, Jacques S.	190	Bridgeton
Veitch, John M.	102	Joplin
Vierling, Stephen E.	190	St. Louis
Vilmer, Charles E.	050	N. Kansas City
Vilmer, Stephen E.	050	N. Kansas City
Wagner, John R.	190	St. Louis
Wakeman, Newt, Jr.	082	Springfield
Wayne, Sherwyn J.	190	St. Louis
Weed, Daniel D.	125	Kansas City
Weise, Marc W.	190	St. Louis
Weltmer, John B., Jr.	190	St. Louis
Wester, William T.	042	Cape Girardeau
Whitaker, James H.	125	Kansas City
White, Newton B.	190	St. Louis
Whiteside, Leo A.	190	St. Louis
Williams, Joseph	190	St. Louis
Wittgen, Edward M.	190	St. Louis
Wolf, Marion L.	082	Springfield
Wright, Rick W.	190	St. Louis
Yost, John G., Jr.	125	Girard, KS
Zehnder, Kenneth W.	190	St. Louis
***Zipper, Ronald**	050	N. Kansas City

Other (OS)

Darmadi, Daniel	125	Kansas City
Rotskoff, Kenneth S.	190	St. Louis
Spellman, Michael	190	St. Louis
Volshteyn, Boris	026	Columbia

Otolaryngology (OTO)

Ailor, Edgar I.	026	Columbia
Allphin, Allan L.	082	Springfield
Barnhill, Floyd R.	082	Springfield
Benecke, James E., Jr.	190	St. Louis
Berkowitz, Wallace P.	190	St. Louis
Bonacorsi, John	190	Bridgeton
***Bosley, Carl E.**	034	Poplar Bluff

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*Doctor of Osteopathy

Branham, Gregory H.	190	St. Louis
Brown, Rebecca L.	082	Springfield
Burroughs, Nathan D.	050	N. Kansas City
Campbell, Gregory S.	026	Columbia
Christiansen, Sidney G.	030	St. Joseph
***Coffman, Avon C.**	125	Kansas City
Cook, Paul R.	026	Columbia
Coonce, Don C.	042	Cape Girardeau
Cotton, Thomas R.	125	Kansas City
Craig, Robert D.	002	St. Louis
Davis, Sheldon	190	Florissant
Davis, William E.	026	Columbia
Denninghoff, James S.	026	Columbia
Devine, Mark W.	050	N. Kansas City
Dlabal, Luke J., Jr.	125	Independence
Donovan, Thomas J.	190	St. Louis
Druck, Norman S.	190	Chesterfield
Dunfield, Jay A.	125	Kansas City
Ehlert, Tamara K.	190	St. Louis
Ehrlich, Carl F.	190	St. Louis
Eisenbeis, John F.	190	St. Louis
Ellis, John C.	125	Independence
Estrem, Scott A.	026	Columbia
Eyen, Thomas P.	125	Overland Park, KS
Forsen, James W., Jr.	002	St. Louis
Freeman, Jerry C.	125	Kansas City
Friedman, William H.	190	St. Louis
Goebel, Joel A.	190	St. Louis
Guastello, Joseph R.	125	Kansas City
Guastello, Mario J.	125	Kansas City
Hahn, Frederick W.	125	Independence
Ham, Kevin R.	034	Poplar Bluff
Hantz, Oscar	190	Florissant
Hartman, James M.	190	St. Louis
***Hechler, Mark L.**	110	Warrensburg
Herzog, Jacques A.	190	Chesterfield
Hill, David K.	125	N. Kansas City
Hughes, Michael F.	125	Kansas City
Ingram, Donald R.	190	Festus
Jung, Christopher H.	042	Cape Girardeau
Katsantonis, George	190	St. Louis
Kendall, Forrest H.	125	Kansas City
King, Dana M., III	030	St. Joseph
Kirsch, Jeffrey P.	190	St. Louis
Kletzker, George R.	190	St. Louis
Knudson, Dennis R.	026	Columbia
Kokoska, Mimi S.	002	St. Louis
Krebs, Festus J., III	125	Kansas City
Kroeger, George B., Jr.	190	St. Louis
Lampros, William P.	190	St. Louis
Levine, Laurence A.	190	St. Charles
Lima, Jose A.	190	St. Louis
Loynd, Robert C.	190	St. Louis
Luetje, Charles M.	125	Kansas City
Mangum, William B.	125	Independence
Marchiando, Albert W.	074	Washington
Martin, Richard A.	042	Cape Girardeau
Marty, David R.	058	Jefferson City
Maslan, Mark J.	125	Overland Park, KS
McDonald, Robert J.	058	Jefferson City
McGonigle, Michael M.	102	Joplin
McIntee, Rae A.	125	Kansas City
McKenzie, Randolph A.	125	Kansas City
McKinney, John W.	190	St. Louis
Mertz, Janet S.	125	Kansas City
Moritz, Gerald	002	Bridgeton
Neely, J. Gail	190	St. Louis
Pavlovich, Andrew S.	125	Independence
Piccirillo, Jay F.	190	St. Louis
Price, Richard B.	125	Overland Park, KS
Reichert, Timothy J.	190	St. Louis
Renner, Gregory J.	026	Columbia
Ridenour, Brock D.	190	St. Louis
Roh, Lynn H.	125	Kansas City
Schrick, Richard E.	190	St. Louis
Schroeder, Walter A., Jr.	042	Cape Girardeau
Seiden, Gerald D.	125	Kansas City
Sessions, Donald G.	190	St. Louis
Shagets, Frank W.	102	Joplin
Sherman, David M.	082	Springfield
Singleton, Marvin A.	102	Joplin
Smith, Courtland P., Jr.	070	Kennett
Smith, Peter G.	190	St. Louis
Snow, Jon F.	082	Springfield
Spake, R. Vanneman	125	Kansas City
Spector, Gershon	190	St. Louis
Stith, John A.	190	St. Louis
Stroble, Mark	190	St. Louis
Templer, Jerry W.	026	Columbia
Thawley, Stanley E.	190	St. Louis
Thedinger, Bradley S.	125	Kansas City
Viers, Wayne A.	190	St. Louis
Walls, Kelvin	125	Independence
Waxman, Joel E.	082	Springfield
Wible, Jerry C.	082	Springfield
Wild, Alan P.K.	190	Chesterfield
Willman, Martin L.	189	St. Charles
Wolfe, James B.	082	Springfield
Yates, Karen	042	Cape Girardeau
Zitsch, Robert P., III	026	Columbia

Pathology (PTH)

Alexander, Susie	002	Kansas City
Anderson, Margaret R.	002	St. Peters
Arthur, Gerald L.	026	Columbia
Bari, Wagih A.	190	St. Louis
Benson, Russell L.	125	Kansas City
Blair, Olga M.	190	Orlando, FL
Bollozos, George D.	190	Ballwin
Bourgeois, Curtis H.	026	Columbia
Brangle, Robert W.	190	St. Louis
Breckenridge, Robert L.	050	Kansas City
Brink, David S.	190	St. Louis
Bucher, William C.	026	Columbia
Burch, Timothy K.	125	Overland Park, KS
Callaway, Lawrence A.	125	Kansas City
Carlson, John V.	014	Mexico
Case, Mary E.	190	St. Louis
Caughron, Michael R.	125	Kansas City
Cento, Donald P.	202	Sikeston
Charles, Elaine Z.	190	St. Louis
Cortese, Cherise	215	Kirkwood
Costin, Jimmy L.	034	Poplar Bluff
Craver, Jeffrey L.	190	Bridgeton
Cummings, Kenneth C.	125	Kansas City
Curry, Michael D.	026	Columbia
Darkow, Grant V.	026	Columbia
Dehner, Louis P.	190	St. Louis
DeFeo, Theodore C.	125	Kansas City
Dorzab, William E.	125	Overland Park, KS
Dumadag, Virgilio P.	190	St. Louis
Durr, Jon W.	190	Florissant
Evans, Maria L.	026	Columbia
Ferris, Charles W., Jr.	190	St. Louis
Fritzlen, Thomas J.	125	Overland Park, KS
Galblum, Larry I.	125	Kansas City
Gauthier, Charles P.	125	Kansas City
Gerdes, John A.	082	Springfield
Givler, Robert L.	125	Kansas City
Hall, Stanley G.	150	Hannibal
Hamel, Peter C.	150	Hannibal
Havlioglu, Necat S.	190	St. Louis
Henry, Lawrence D.	058	Columbia
Henry, Mary M.	125	Kansas City
Hopson, David K.	190	St. Charles
Horn, Paul C.	042	Cape Girardeau
Hurly, Michael P.	102	Joplin
Ingram, Ellis A.	026	Columbia

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*Doctor of Osteopathy

Johnson, Gareth R.	Independence	125
Johnson, Gordon L.	Festus	106
Johnson, Steven M.	Clayton	190
Jones, Randall W.	Independence	125
Kang, Juan	St. Louis	190
Keiper, Arthur S., III	Moberly	026
Keitges, Pierre W.	Overland Park, KS	125
King, Gregory S.	St. Louis	190
Kissane, John M.	St. Louis	190
Kleopfer, Lynn L.	Columbia	026
Kraus, Frederick T.	St. Louis	190
Landgraf, James R.	Independence	125
LaBach, James P.	Overland Park, KS	125
Levy, Beth K.	St. Louis	190
Litton, Nancy J.	Blue Springs	125
Lombardo, Joseph A.	St. Louis	190
Marshall, Hal E.	Overland Park, KS	125
Martin, Scott A.	Chesterfield	190
McDonald, Margaret E.	Joplin	102
McIntire, Timothy L.	Jefferson City	058
Millett, Ruth E.	Kansas City	125
Morrison, R. Gideon	West Plains	206
Munoz, Phillip A.	Kansas City	125
Ost, Mark D.	Kansas City	125
Paez, Mauro A.	St. Louis	190
Patrick, Roman L.	St. Louis	190
Perez, Blanca M.	St. Louis	190
Peterson, Ila M.	Overland Park, KS	125
Pintado, Susan O.	Joplin	102
Pittman, David L.	Columbia	026
Pittman, Gerald R.	St. Louis	190
Poger, Marshall E.	St. Louis	190
Prey, Marianne U.	St. Louis	190
Racela, Luz S.	Leawood, KS	125
Ramos, Ricardo R.	St. Louis	190
Rao, Sumati	St. Louis	190
Rawson, Perry G.	Washington	074
Rollo, John L.	St. Louis	190
Rondinelli, Robert D.	Kansas City	125
Rudloff, Mary A.	St. Louis	002
Salvador, Antonio	St. Louis	190
Seitz, Elson F.	Independence	125
Shah, Sheila	St. Joseph	030
Shelley, James M.	Springfield	082
Short, Charles D.	St. Louis	190
Silliman, York E.	St. Joseph	030
Smid, David M.	Springfield	082
Stahr, William D.	Cape Girardeau	042
Sueper, Robert H.	St. Louis	190
Summerfield, Anita	Springfield	206
Tritz, Denise M.	Jefferson City	058
Turgeon, Ronald P.	St. Louis	190
Vergara, Gerardo G.	Kansas City	125
Villanueva, Angela A.	Overland Park, KS	125
Vo, Thuy-Lieu T.	St. Louis	190
Wachter, Ronald M.	Springfield	082
Wiench, DeLane F.	Rolla	135
Wikenheiser, Kathryn A.	St. Louis	215
Young, Thomas W.	Kansas City	125
Zacharias, Sara	Columbia	026

Pediatrics (PD)

Aceto, Thomas, Jr.	St. Louis	190
Adams, Susan E.	St. Louis	190
Allen, Jerry H.	Washington	074
Amjad, Mohammad T.	St. Louis	190
Andrews, Elizabeth J.	Springfield	082
Baker, Marion H.	Jefferson City	058
Barker, Edward T.	St. Louis	190
Barter, Bruce	Leawood, KS	125
Beesley, Kari	Kansas City	002
Belen, Marietta	Festus	106
Benoist, Walter F.	Chesterfield	190
Berman, Paul M.	St. Louis	190
Bernhardson, Paul D.	Columbia	026
Birmingham, Jean E.	St. Louis	190
Blim, R. Don	Kansas City	125
Bloomberg, Gordon R.	Chesterfield	190
Bordy, Marvin D.	Kansas City	125
Bost, Roger K.	Poplar Bluff	034
Bouhasin, John D.	St. Louis	190
Bowers, James E.	Kirkwood	190
Braddock, Stephen	Columbia	026
Brady, Teresa M.	Lee's Summit	125
Brehm, Martha A.	Joplin	102
Britton, Loretta M.	Kansas City	125
Brown, Marilyn	Florissant	215
Browning, Sarah E.	Kansas City	215
Bunge, Nancy J.	Mexico	014
Burgdorf, Max H.	Bridgeton	190
Burry, Virgil F.	Blue Springs	125
Bussmann, Yvonne L.	Springfield	082
Cantor, Harvey E.	St. Louis	190
Carnahan, Charles E.	Columbia	026
Casey, Eliot C.	St. Louis	190
Charette, Richard P.	Kansas City	125
Chauhan, Nazar C.	Poplar Bluff	034
Chun, Chung S.	Kansas City	125
Clever, Henry W.	St. Charles	189
Clothier, Robert W.	Independence	125
Cockerell, Charles F.	Blue Springs	125
Cokingtin, Diana L.	Kansas City	125
Cokingtin, Leovigildo C.	Independence	125
Conley, Brian S.	Jefferson City	058
Cook, Katherine S.	Rolla	135
Cygan, Ronald W.	Kansas City	125
Dattel, F. Scott	Overland Park, KS	002
Dempsey, Maureen E.	Columbia	026
DeCastro, Fernando J.	Pilot Knob	138
DeSilva, Ananda	Hazelwood	190
Diehl, Elizabeth W.	St. Louis	190
Dinkins, James A.	Cape Girardeau	042
Duling, Gerald J.	St. Charles	189
Ewing, Lesley L.	Kansas City	125
Farberman, Elliott	Florissant	190
Fernandez, Fernando	St. Joseph	030
Fitzmaurice, Laura S.	Kansas City	125
Floyd, Marla J.	Springfield	082
Flug, Eric J.	St. Louis	190
Forgue, Donald R.	Kansas City	125
Friedman, Ira J.	Washington	074
Fusselman, Jon M.	Springfield	082
Gassman, Ann A.	Kansas City	125
Gauer, Robert J.	Kansas City	050
Gellman, Elliot F.	St. Louis	190
Glines, Michael H.	Arnold	190
Glotzbach, Ellen S.	Kansas City	125
Goldberg, Joseph P.	Mentor, OH	125
Goldstein, David E.	Columbia	026
Goler, Michael R.	Springfield	082
Goodman, Gary M.	Chesterfield	190
Griesemer, Bernard A.	Springfield	082
Groshong, Ted D.	Columbia	026
Grunt, Jerome A.	Kansas City	125
Guyer, Emily	Columbia	026
Hall, Robert T.	Kansas City	125
Hanks, Michael S.	Springfield	082
Hansen, Thomas L.	Independence	125
Harris, David J.	Kansas City	125
Harris, Weldon L.	Independence	125
Harrison, Thomas J., Jr.	St. Charles	189
Harwell, J. Larry	St. Louis	190
Hellweg, Raymond W.	Florissant	190
***Hoffman, James E.**	Cape Girardeau	042
Holmes, Nancy E.	St. Louis	190
Horan, John J., Jr.	St. Louis	190
Howard, Campbell P.	Kansas City	125
Ip, Aidan W.	St. Louis	190

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Jackson, Mary Anne	002	Kansas City
Jacobson, Jill D.	125	Kansas City
James, Elizabeth J.	026	Columbia
Jones, Robert R.	214	Nevada
Kanarek, Joseph	125	Kansas City
Keefe, David M.	189	St. Charles
Kemp, Michele E.	190	Chesterfield
Khan, Abdul G.	190	Arnold
Khanfar, Nasha't M.	202	Sikeston
Khurana, Satish K.	125	Lenexa, KS
Kilbride, Howard W.	125	Kansas City
King, Allison A.	215	Clayton
Knapp, Jane F.	125	Kansas City
Knock, Henry L.	190	St. Louis
Koenig, Joel S.	190	St. Louis
Kosse, Karl E.	030	St. Joseph
Krahn, Eve M.	050	Kansas City
Kreusser, Katherine L.	190	St. Louis
Krishna, Padma	125	Shawnee Mission, KS
Kronemer, Norton S.	190	St. Louis
Limpiphiphatn, Ester P.	174	Perryville
Loo, Kek-Khee	215	St. Louis
Mann, James K.	150	Hannibal
McElroy, George L., III	058	Jefferson City
McIntosh, Michele C.	125	Independence
McNeal, Douglas M.	082	Springfield
Mestres, Hugh M.	190	St. Louis
Meyer, John W.	082	Springfield
Miller, Suzanne L.	190	Grover
Mitra, Nirmal K.	125	Kansas City
Monteleone, Patricia L.	190	St. Louis
Morgan, Mary	002	St. Louis
Motier, Thomas H.	190	St. Louis
Muraywid, Ahmad H.	014	Mexico
Murphy, Timothy P.	030	St. Joseph
Nash, Alison C.	190	St. Louis
Newman, William R.	102	Joplin
Nicholis, G. Ronald	125	Kansas City
Nile, David A.	190	St. Louis
Nitta, Diane M.	082	Springfield
Nussbaum, Larry	050	Liberty
O'Neil, Jerome H., Jr.	190	St. Louis
Olson, Gary S.	042	Cape Girardeau
Oppermann, Karen J.	125	Independence
Otis, Stephanie A.	002	St. Louis
Overend, Don S.	082	Springfield
Palcheff, Chris L.	082	Springfield
Peterson, Frederick D.	190	St. Louis
Phillips, Abraham M.	190	St. Louis
Pitiyanuvath, Tasanaporn	125	Kansas City
Plax, Steven I.	190	St. Louis
Powell, Alan E.	125	Independence
Reed, Timothy F.	178	Sedalia
Rejent, Anthony J.	190	St. Louis
Reyes, Lirio M.	082	Springfield
Rice, Kathleen G.	082	Springfield
Richards, Pamela	215	St. Louis
Rising, Dean R.	082	Springfield
Roberts, Charles C.	125	Kansas City
Roberts, Phyllis G.	030	St. Joseph
Ross, William J.	190	Bridgeton
Rudolph, Joseph C.	190	Fenton
Ryser, Carol A.	125	Kansas City
Sakmar, Douglas A.	190	St. Louis
Sammon, T. James	082	Springfield
Sato, George	190	Chesterfield
Sato, Richard W.	190	Chesterfield
Schlansky, Howard J.	189	St. Charles
Schmidt, Martin P.	190	St. Louis
Sheehan, Michael B.	125	Kansas City
Sherman, W. Gary	190	Chesterfield
Simmons, Connie D.	042	Cape Girardeau
Smith, Arnold L.	026	Columbia
Solanki, Nareshkumar J.	190	Wentzville
Sponenberg, Don D.	082	Springfield
Stiaszny, Louis K.	125	Kansas City
Sultan, Tipu	190	Florissant
Suseela, Dasari	125	Kansas City
Tenorio, Genoveva	158	Albany
Thompson, F. Gregg	030	St. Joseph
Tillman, Mary A.	190	St. Louis
Tolan, Robert W., Jr.	190	St. Louis
Troug, William E.	125	Kansas City
Tschudin, Garland	190	St. Louis
Tsifutis, Argyrios A.	190	St. Louis
Tungsiripat, Soros	070	Kennett
Umar, Ibrahim S.	189	St. Peters
Vietti, Teresa J.	002	St. Louis
Walentik, Corinne	190	St. Louis
Walker, Orville C.	125	Independence
***Wasserman, Gary S.**	125	Kansas City
Waxelman, Roger J.	190	Ballwin
Weldon, Virginia V.	190	St. Louis
Westerfeld, Roy A.	189	St. Charles
Wheeler, Camilla A.	058	Jefferson City
Wimmer, Warren J.	190	Florissant
Wool, Gerald	190	St. Louis
Zahn, Robert L.	082	Springfield

Pediatric Allergy (PDA)

Cannon, Richard E.	189	St. Charles
Corry, James M.	190	St. Louis
Siegel, Charles	050	Gladstone

Pediatric Cardiology (PDC)

Canent, Ramon V.	125	Kansas City
Exil, Vernat	215	St. Louis
Gowdamarajan, Rengasamy	125	Kansas City
Hubbell, Marius M., Jr.	125	Kansas City

Pediatric Neurology (PDN)

Tremblay, Gerald F.	002	Kansas City

Pediatric Radiology (PDR)

Ritter, John L.	082	Springfield
Wadsworth, Deborah T.	190	St. Louis

Pediatric Surgery (PDS)

Ashcraft, Keith W.	125	Overland Park, KS
Bell, Martin J.	190	St. Louis
Cradock, Thomas V.	190	St. Louis
Helikson, Mary A.	026	Columbia
Murphy, John P.	125	Overland Park, KS
Sharp, Ronald J.	125	Overland Park, KS

Physical Medicine & Rehabilitation (PM)

Al-Shathir, Saad	102	Joplin
Alias, Susy	190	St. Louis
Berger, Gary G.	125	Overland Park, KS
Clark, Jennifer L.	026	Columbia
Conway, Robert R.	026	Columbia
Del Rosario, John E.	190	St. Louis
Fischer, Ronald, L.	190	Chesterfield
Gnatz, Steven	026	Columbia
Hoffarth, Sharon C.	190	St. Louis
Karges, Melvin D.	125	Joplin
Kelly, Charles R.	125	Kansas City
Knakal, Roger C.	125	Kansas City
Lieb, Thomas F.	190	St. Louis
Lytle, Edwin L.	190	St. Louis
Mauldin, Charles C.	082	Springfield

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Middleton, Mary Jo	030	St. Joseph
Mohsen, Aly M.	082	Springfield
Page, Jennifer L.	190	St. Louis
Pryor, Harold J.	125	Kansas City
Randolph, Bernard C., Jr.	002	Bridgeton
*Rupright, S. Jon	058	Columbia
Samudrala, Suseela	190	St. Louis
Virtucio, Anna Liza C.	215	St. Louis
Wheeler, Eden	125	Independence
Wice, Martin B.	190	St. Louis
*Woods, Brenda L.	058	Jefferson City
Zarr, James S.	125	Kansas City

Plastic Surgery (PS)

Barnthouse, Joseph R.	125	Kansas City
Bennett, Danny L.	125	Kansas City
Cabbabe, Edmond B.	190	St. Louis
Caplin, David A.	190	St. Louis
Coin, Richard E.	190	St. Louis
Copeland, Jeffrey G.	189	St. Charles
Corwin, Kenneth D.	190	St. Louis
Crandall, Richard E.	190	Chesterfield
Danielsson, Ernst P.	082	Springfield
Deisher, David M.	042	Cape Girardeau
DePriest, Michael D.	030	St. Joseph
Domann, Darrel D.	082	Springfield
Eades, Joseph W.	190	Chesterfield
Ettelson, Charles D.	190	Chesterfield
Feliciano, Wilfrido C.	190	Maryland Heights
Fortin, Don G.	050	Kansas City
Francel, Thomas J.	002	St. Louis
Geraghty, Thomas E.	125	Kansas City
German, David S.	190	St. Louis
Geter, Rodney K.	082	Springfield
Goldstein, Marcy A.	002	St. Louis
Gonzalez, Federico	125	Shawnee, KS
Guinn, O. Allen, III	125	Independence
Gutek, E. Philip	125	Kansas City
Hart, William G., Jr.	190	St. Louis
Heimburger, Richard A.	120	Osage Beach
Higgs, Philip E.	190	St. Louis
Huffaker, William H.	190	St. Louis
Johnson, Charles J.	190	St. Louis
Jones, Timothy R.	190	St. Louis
Kaplan, Michael F.	026	Columbia
Kester, Carla G.	082	Springfield
Khouri, Roger K.	190	KeyBiscayne, FL
Kofkoff, Richard L.	190	Bridgeton
Koo, Michele D.	190	St. Louis
Kraemer, Bruce A.	190	St. Louis
Lakusiewicz, Ronald J.	034	Poplar Bluff
Lamb, Jerome P.	125	Blue Springs
Lomax, John E.	208	Branson
Lund, Herluf G., Jr.	190	Chesterfield
MacKinnon, Susan E.	190	St. Louis
Marsh, Jeffrey L.	190	St. Louis
McClung, Mark W.	125	Kansas City
McGuire, Patricia A.	190	St. Louis
Meystrik, Rosellen S.	082	Springfield
Mischnick, Carol R.	190	Chesterfield
Mossie, Raymond D.	002	Kansas City
O'Connell, Timothy	190	St. Louis
Onken, Henry D.	190	St. Louis
Paletta, Francis X., Jr.	190	St. Louis
Payne, Meredith C.	190	Chesterfield
Price, Carl I.	082	Springfield
Puckett, Charles L.	026	Columbia
Reynolds, William R.	082	Springfield
Ribaudo, J. Michael	190	St. Louis
Rinehart, Gregory C.	190	St. Louis
Rodgers, Jody A.	058	Jefferson City
Rottler, Paul D.	190	St. Louis
Ruehl, Albert F.	190	St. Louis
Scheu, James H.	190	St. Peters
Seaberg, John J., III	026	Columbia
Sherrod, Duane W.	102	Joplin
Stevens, Sheridan	125	Independence
Strain, Herb A.	125	Kansas City
Stromberg, Brent V.	190	St. Louis
Thompson, Frederick E.	050	Liberty
Tobin, Gregory A.	042	Cape Girardeau
Towle, Dana R.	050	Kansas City
Wall, Norman R.	082	Springfield
Walton, Patrick J.	125	Kansas City
Webb, Harry E.	125	Kansas City
White, Bruce I.	190	St. Louis
Winsky, Arlen D.	082	Springfield
Young, Mark E.	125	Kansas City
Young, Robert A.	190	Chesterfield
Young, Vernon L.	190	St. Louis

Psychiatry (P)

Ajans, Zaki A.	014	Mexico
Aleksander, Bernardo G.	190	El Paso, TX
Allison, James B.	082	Springfield
Anderson, Thomas R.	026	Columbia
Baird, Keim L.	189	St. Charles
Bartulica, Nicholas	030	St. Joseph
Batterson, James R., Jr.	125	Kansas City
Beck, David A.	026	Columbia
Beitman, Bernard D.	026	Columbia
Berland, David I.	190	Chesterfield
Biggs, John	190	St. Louis
Bright, James E.	082	Springfield
*Burns, Bernard C., III	042	Cape Girardeau
Calabria, Rafael	214	Nevada
Calhoun, Joshua W.	190	St. Louis
Callahan, Joseph D.	190	St. Louis
Callaway, Jo J.	125	Kansas City
Choi, Sei Young	189	St. Charles
Cole, Sherman W.	125	Kansas City
Corvalan, Juan C.	190	St. Louis
Crane, John B.	074	Washington
Croughan, Jack L.	190	St. Louis
Crumpacker, Margaret	190	St. Louis
Curry, D. Troy	190	St. Louis
Davis, Mary A.	190	St. Louis
Day, Chester L.	125	Prairie Village, KS
Dewald, Paul A.	190	St. Louis
Dewein, Edward G.	190	St. Louis
Dick, M. Marga	026	Ashland
Dos Santos, Enrique	026	Columbia
Dowell, George H.	190	St. Louis
Edmisten, Jack	125	Nevada
Eppright, Thomas D.	026	Columbia
Finn, Murray E.	190	St. Louis
Frazier, Robert E.	026	Columbia
Garcia, Eduardo L.	190	St. Louis
Gavankar, Sharad S.	102	Joplin
Glenn, Theodore J.	042	Cape Girardeau
Gonzalez, Alicia D.	190	St. Louis
Grindlinger, Howard M.	034	Poplar Bluff
Grossberg, George T.	190	St. Louis
Guze, Samuel B.	190	St. Louis
Hagen, Duane Q.	190	St. Louis
Hartnett, Anna E.	190	Clayton
Hartnett, Thomas D.	190	St. Louis
Hay, Donald P.	190	St. Louis
Hicks, Frederick G.	190	St. Louis
*Hogan, Patricia E.	030	St. Joseph
Holemon, R. Eugene	190	St. Louis
Hornstra, Robijn K.	125	Kansas City
Houghton, Howard L.	125	Kansas City
Hucke, Samuel T., III	125	Kansas City
Hudgens, Richard W.	190	St. Louis
Hughes, Derek	026	Columbia
Irvin, Wm. M.	190	St. Louis
Jones, Georgia A.	190	St. Louis

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Jones, Laird E.	082	Springfield
Kamath, K.P.S.	042	Cape Girardeau
Katf, Nicola Y.	050	N. Kansas City
Khan, Khawla B.	002	St. Louis
Khojasteh, Saaid	002	St. Charles
Kitchin, Winston H.	190	St. Louis
Kleinschmidt, Donn C.	190	St. Louis
Klemm, J. Martin	125	Kansas City
Knowles, R. Raymond	190	St. Louis
Kory, Steven M.	102	Joplin
Krojanker, David N.	190	St. Louis
Krojanker, Rolf J.	190	St. Louis
Kuhn, Lawrence F.	190	Bridgeton
Kulak, Gary	190	St. Louis
Kulick, Eric M.	125	Prairie Village, KS
Lamb, Wanda	190	St. Louis
LeFevre, Philip J.	082	Springfield
Lipschitz, Ervin	190	St. Louis
Liss, Jay L.	190	St. Louis
Lucas, Thomas G.	190	St. Louis
Lyskowski, John C.	058	Jefferson City
Malmberg, Virgil L.	190	Chesterfield
McAfee, Gordon	082	Springfield
McGahee, C. Leon	190	St. Louis
Mendez, Maria A.	082	Springfield
Meyer, Jay L.	190	St. Louis
Meyers, Robert W.	190	St. Louis
Milgram, Byron A.	125	Kansas City
Miller, Jule P.	190	St. Louis
Miller, Pamela S.	135	Rolla
Montani, David M.	215	St. Louis
Moran, Thomas M.	190	St. Louis
Moritz, K. Lynne	190	St. Louis
Munro, John S.	125	Kansas City
Nair, Jyotsna	026	Columbia
Nieuwenhuizen, Maarten	026	Columbia
Nowotny, Thomas J.	190	St. Louis
Ohlms, David L.	190	St. Louis
***Olomon, Angela S.**	050	Gladstone
Othmer, Ekkehard	050	Kansas City
Packman, Paul	190	St. Louis
Parks, Joseph J.	026	Jefferson City
Parks, Lyle F.	082	Springfield
Parwatikar, Sadashiv D.	190	St. Louis
Peterson, Stephen E.	125	Kansas City
Pew, Becky A.	190	St. Louis
Pickens, Andrew T.	190	St. Louis
Post, Stephen L.	190	St. Louis
Pribor, Elizabeth F.	190	St. Louis
Pro, John D.	125	Kansas City
Quiason, Arturo G.	125	Independence
Rankin, Diane	190	St. Louis
Ratnam, Dasari V.	125	Kansas City
Reddy, Agara S.	026	Columbia
Renner, Julie A.	190	St. Louis
Ricci, Walter F.	125	Shawnee Mission, KS
Richardson, Thomas F.	190	St. Louis
Rizzo, Adolfo E.	190	St. Charles
Robinson, Gordon H.	190	St. Louis
Rosenthal, Randall	190	St. Louis
Ryall, Jo-Ellyn M.	190	St. Louis
Sabet, Abdollah A.	190	Ballwin
Saghir, Marcel T.	190	St. Louis
Salazar, Berette A.	002	St. Louis
Schmitz, John M.	125	Kansas City
Schwarz, Luis H.	190	St. Louis
Segraves, Steven D.	125	Kansas City
Sheffner, Paul W.	190	St. Louis
Shen, Winston W.	190	St. Louis
Shopper, Moisy	190	St. Louis
Simmons, Donald D.	125	Kansas City
Simon, Nathan M.	190	St. Louis
Sitzman, Everette T.	125	Kansas City
Solomon, Nancy A.	198	Marshall
Soltys, Stephen M.	026	Columbia
Soorya, Narendir T.	190	St. Louis
Stewart, Harry A.	125	Kansas City
Stillings, Wayne A.	190	St. Louis
Tilzer, Seth	190	Florissant
Trikha, Ajit	002	Belleville, IL
True, James D.	050	Kansas City
Trugly, Edith S.	190	St. Louis
Valera, Salvador S.	030	St. Joseph
Vandivort, Paul M., Jr.	190	St. Louis
Viamontes, Jorge A.	190	St. Louis
Vickar, Garry M.	190	Florissant
***Williams, Robert J.**	030	St. Joseph
Wolff, Harold D.	190	St. Louis
Yates, John M.	058	Jefferson City

Public Health (PH)

Biek, Richard W.	190	St. Louis
Biery, Richard M.	125	Kansas City
Kimmey, James R.	190	St. Louis

Pulmonary Disease (PUD)

Beller, Thomas A.	125	Kansas City
Bittle, Bradley K.	042	Cape Girardeau
Bower, James S.	125	Kansas City
Brabson, John H.	082	Springfield
Brischetto, Michael J.	190	St. Louis
Brook, Charles J.	125	Kansas City
Devins, George S.	125	Kansas City
Fluegel, Wendy L.	125	Kansas City
Goheen, John R.	125	Kansas City
Grimm, Mark E.	082	Springfield
Hargis, James L.	082	Springfield
Harrison, Garth F.	125	Kansas City
Khan, Khalid I.	042	Cape Girardeau
King, John V., Jr.	190	Ballwin
Koh, David W.	190	St. Louis
Lampton, Lawrence M.	026	Columbia
Lerner, Scott A.	125	Kansas City
Mahmoud, Said F.	125	Kansas City
Pingleton, William W.	050	Shawnee Mission, KS
Reddy, Anchala N.	206	West Plains
Scacewater, Rick	102	Joplin
Schlozman, Danl L.	125	Kansas City
Siler, Thomas M.	189	St. Charles
***Thomas, Norvin E.**	014	Mexico
Wiant, James R.	190	St. Louis
Wood, John A.	190	Chesterfield

Radiation Oncology (RO)

Baglan, Robert J.	190	St. Louis
Bedwinek, John M.	190	St. Charles
Bryer, Mark P.	026	Columbia
Butler, David F.	190	Chesterfield
Cozad, Scott C.	125	Kansas City
Devineni, V. Rao	190	Bridgeton
Fu, Anna L.	190	St. Louis
Garcia, Delia M.	190	St. Louis
Grigsby, Perry W.	190	St. Louis
Hanes, Lily A.	190	Golden Eagle, IL
Lee, Fransiska A.	190	St. Louis
Lin, Hsiu-San	190	St. Louis
Massey, Vickie	125	Kansas City
McDonough, Michael	190	St. Louis
Mill, William B., Jr.	190	St. Louis
Miller, Joseph P.	042	Cape Girardeau
Morrison, Richard A.	125	Independence
Myers, Duane E.	102	Joplin
Nigh, Stephen S.	125	Kansas City
Pacheco, Jose M.	082	Springfield
Perez, Carlos A.	190	St. Louis
Pruitt, David	102	Joplin
Robinow, Jay S.	125	Kansas City

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Roy, Tapankumar S.	190	St. Louis
Simpson, Joseph R.	190	St. Louis
Smalley, Stephen R.	125	Kansas City
Sutphen, Eric J.	190	St. Louis
Swanson, Robert G.	002	Ocean Springs, MS
Walz, Bruce J.	190	St. Louis
Zivnuska, Frederick R.	190	St. Louis

Therapeutic Radiology (TR)

Abadir, Rushdy	026	Columbia
Boles, Murray	026	Columbia
Murrell, H. Jerry	026	Columbia
Paradelo, Jorge C.	125	Kansas City
Rogers, Joseph D.	082	Springfield
Throne, Ben J.	125	Kansas City
Westgate, Steven J.	026	Columbia

Radiology (R)

Abodeely, Daniel A.	190	St. Louis
Al-Aly, Robert M.	190	Chesterfield
Albritton, Michael A.	082	Springfield
Anderson, D. Claire	190	St. Louis
Baber, William W.	190	St. Louis
Bardsley, John L.	190	St. Louis
*Bartow, John H.	030	St. Joseph
Baskurt, Mehmet V.	034	Poplar Bluff
Baula, Armindo G.	190	St. Louis
Berni, Anthony A.	190	St. Louis
Blackwell, Charles W.	026	Columbia
Busse, Paul P.	190	St. Louis
Campbell, William S., Jr.	042	Cape Girardeau
Carls, Garry L.	190	Imperial
Clouse, John W.	082	Springfield
Cohen, Edward	190	St. Louis
Colbert, Robert S.	202	Sikeston
Cook, Marvin A.	190	St. Louis
Corder, Patricia G.	190	St. Louis
Courter, Larry P.	058	Osage Beach
Crotty, John P.	190	St. Louis
Dehner, Jonathan D.	190	St. Louis
DeMotte, Jeanne M.	118	Richmond
Diemer, David P.	190	St. Louis
Diemer, Peter A.	190	St. Louis
*Ditzel, Douglas W.	102	Joplin
Dixon, G. David	125	Shawnee Mission, KS
Egan, Thomas F.	190	St. Louis
Elwing, Terry J.	026	Columbia
Farkas, J. Robert	178	Sedalia
Francisco, Dominic S.	190	St. Louis
Gates, Mark L.	042	Cape Girardeau
Gilula, Louis A.	190	St. Louis
Gregston, J. Leon	082	Springfield
Gubin, Barry A.	125	Kansas City
Gujarati, Subhash B.	034	Poplar Bluff
Gustafson, Jon E.	125	Lee's Summit
Habert, Edward R.	190	Chesterfield
Hassien, Joel D.	150	Hannibal
Hesker, Albert E.	190	Chesterfield
Higgins, Michael D.	042	Cape Girardeau
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Agenda

9:30 - 10 a.m. Registration

10 - 10:10 a.m. Introduction and Orientation

10:10 - 11:10 a.m. The Legal Implications of HB 335
Hon. Timothy C. Harlan, JD, *Columbia*
Missouri House of Representatives, District 23

11:10 a.m. - 12 p.m. IRS Intermediate Sanctions - Learn the Private Inurement/Benefits and Other Tax Exempt Issues That Can Get Physicians and Hospitals In Trouble
Dee Rich, *Atlanta, GA, KPMG Peat Marwick LLP*

12 - 1 p.m. Lunch

1 - 2 p.m. Take the Fraud and Abuse Challenge!
Elizabeth Swinton Schoen, JD, *Atlanta, GA*
KPMG Peat Marwick LLP

2 - 3 p.m. What You Always Wanted to Ask a Physician or Lawyer in Public but Were Afraid To

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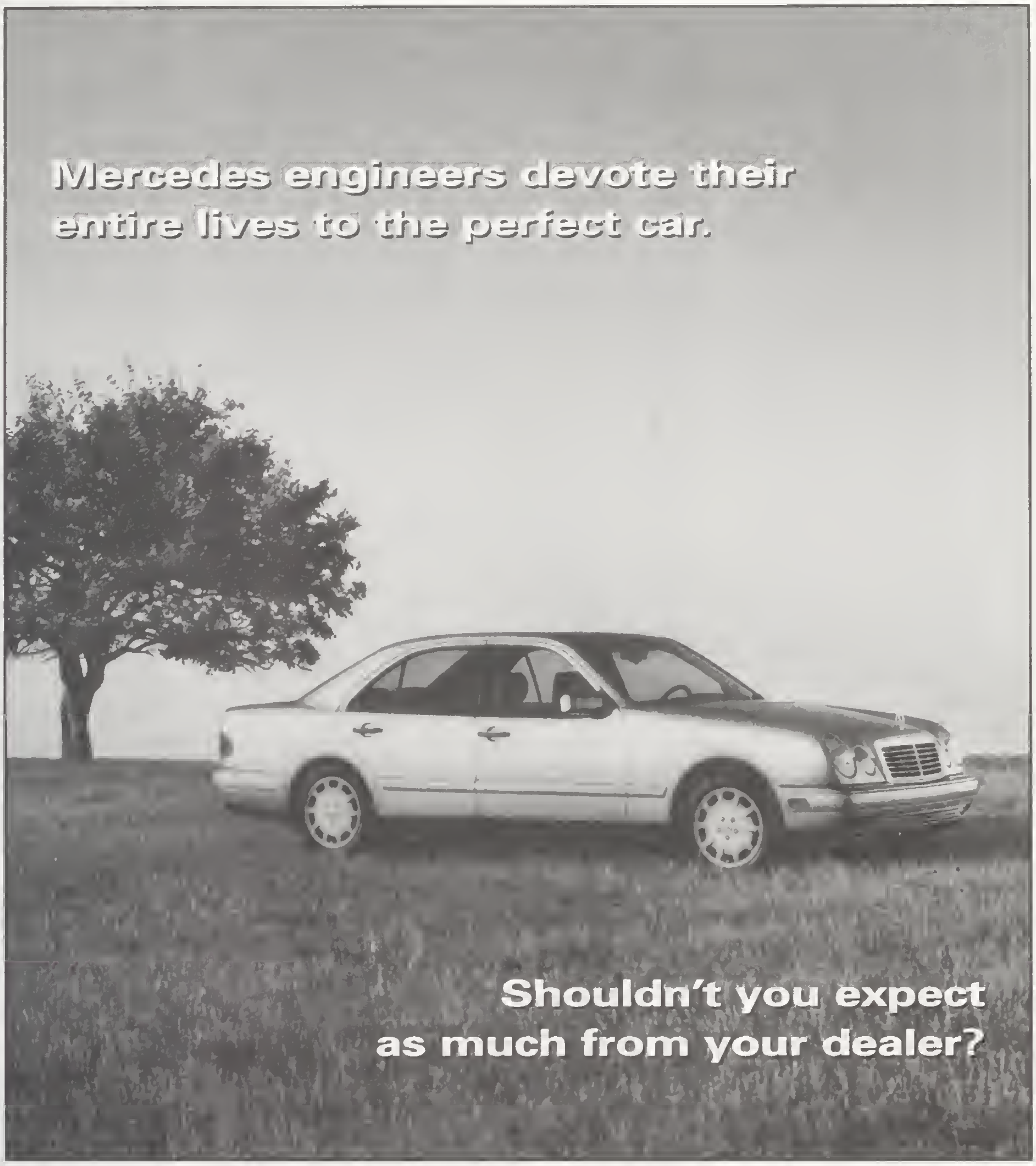
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ABS	Abdominal Surgery
ADL	Adolescent Medicine
AI	Allergy & Immunology
AM	Aerospace Medicine
AN	Anesthesiology
BE	Broncho-Esophagology
BLB	Bloodbanking
CCM	Critical Care Medicine
CD	Cardiovascular Disease
CDS	Cardiovascular Surgery
CHN	Child Neurology
CHP	Child Psychiatry
CLP	Clinical Pathology
CRS	Colon & Rectal Surgery
D	Dermatology
DIA	Diabetes
DMP	Dermatopathology
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology
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FPS	Facial Plastic Surgery
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GER	Geriatrics
GP	General Practice
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HS	Hand Surgery
HYP	Hypnosis
ID	Infectious Diseases
IG	Immunology
IM	Internal Medicine
LAR	Laryngology
LM	Legal Medicine
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N	Neurology
NA	Neuropathology
ND	Neoplastic Diseases
NEP	Nephrology
NM	Nuclear Medicine
NPM	Neonatal-Perinatal Medicine
NR	Nuclear Radiology
NS	Neurological Surgery
OBG	Obstetrics & Gynecology
OBS	Obstetrics
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OS	Other
OT	Otology
OTO	Otolaryngology
P	Psychiatry
PD	Pediatrics
PDA	Pediatric Allergy
PDC	Pediatric Cardiology
PDE	Pediatric Endocrinology
PDR	Pediatric Radiology
PDS	Pediatric Surgery
PH	Public Health
PHO	Pediatric Hematology-Oncology
PM	Physical & Rehabilitation Medicine
PNP	Pediatric Nephrology
PS	Plastic Surgery
PTH	Pathology
PUD	Pulmonary Disease
PYA	Psychoanalysis
PYM	Psychosomatic Medicine
R	Radiology
REN	Reproductive Endocrinology
RHI	Rhinology
RHU	Rheumatology
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U	Urology
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VS	Vascular Surgery

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When the Past Becomes the Present

J. Regan Thomas, MD

I can remember as a kid in the 1950s beginning to hear about radioactive fallout from nuclear testing. I recall that something called "Strontium-90" was being discussed by my parents' friends and occasionally was mentioned on television. That was when the "Cold War" was hotter and the concern about nuclear warfare was on everyone's mind as much or more than nuclear testing. Even in a small town like Joplin, there was a business selling bomb shelters and you could look in the big metal storage tank-like structures right there on the lot.

With that as a typical backdrop for the attitudes of the whole country at the time, it is perhaps understandable that some of the undesirable side-effects of nuclear testing were tolerated or overlooked. If the bad guys were testing and threatening us with an atomic bomb, we should test and continue to develop our own, many would say during that period. Besides, we felt very insulated from all that in the southern Missouri Ozark area. The testing was being done a long way away from us and the whole concept seemed too esoteric and distant to be of real concern.

Forty years later it turns out we were wrong. Nuclear testing effects from that era are back in our conversation. It turns out that southern Missouri Ozark areas were not as insulated as it seemed and in fact we were one of the "hot spots" with high exposure to radiation from the nuclear tests. The National Cancer Institute (NCI) is about to issue a report regarding radiation. Those tests and predictions of present day health effects are beginning to be postulated. An Associated Press (AP) report regarding the NCI findings placed Missouri on the list of states with the highest estimated exposure. There were 90 some nuclear tests performed throughout the 1950s and 12 states including Missouri caught the brunt of the radioactive exposure. Reportedly the highest exposure came from kids drinking milk contaminated with iodine 131. Cows eating contaminated grass produced contaminated milk and it was potentially concentrated in the thyroids of the milk drinking segments of the population, especially kids. The AP report notes that radiation was concentrated in the Ozark region of the state as well as in areas north of the St. Louis vicinity.

Policy and actions that may effect the public health must be considered not only for the present, but for the impact on future years.

Is there an increased rate of thyroid cancer in the population of those areas at risk from the 1950s? Time will tell but already there is talk about compensation to people exposed when they were children. It didn't take long for that to begin to be considered of course.

To me an important lesson is to be learned here. Policy and actions that may effect the public health must be considered not only for the present, but for the impact on future years. Likewise, the public should be educated and informed about the risks. It might be decided as it was then, that the testing was important enough to take the risk. But if so, warn the public and educate them to avoid the risks i.e. don't drink the milk. If policy makers fail to keep the public informed, we will again be facing issues like this in 40 years. MoMed

Adults With Congenital Heart Disease

Richard B. Whiting, MD, FACC, FACP

Two years ago in a letter, I briefly outlined the growing importance of health care for adults with congenital heart disease.[1] Most babies born now with congenital cardiac defects will survive to adulthood either because of relatively minor functional derangement or because of sophisticated surgical care. It is becoming more common for these patients to present as adolescents or adults with unrelated medical, surgical or obstetrical conditions. Some of these patients have very unique anatomy and physiology and therefore represent a definite challenge to medical or surgical care. The risks of inappropriate care are quite real. In a survey of congenital heart disease in the United Kingdom, Somerville noted that 20% of deaths in adult patients were premature or avoidable and often related to some kind of mismanagement.[2] There has been some realization worldwide that this growing population with congenital defects has special needs and there are multiple specialty centers specifically for patients with congenital cardiovascular problems who have reached an age beyond pediatrics. In addition, there are regular international seminars devoted to this subject. There is an informative web site for these patients including information for families as well as physicians. This can be accessed at http://www.cachnet.org. The International Society for Adults with Congenital Cardiac Disease was formed in 1994 to provide a means of sharing scientific and procedural data around the world (ISACCD, 4100 Lake Boone Trail, Suite 201, Raleigh, North Carolina 27607).

Missouri, as a state, is ahead of many others in the recognition of the special needs of so-called grown-up congenital heart patients. There are four separate specialty centers (see box at right) with particular interest and expertise in dealing with the unique problems these patients present. Missouri has a good system of vital statistics which includes statewide experience with congenital heart disease. I am very much indebted to Mr. Jim Davis, Research Analyst at the Center for Health Information and Epidemiology, Missouri Department of Health, for data concerning experience in Missouri during 1995 with congenital cardiovascular problems. During that year, there were 3,090 hospital admissions throughout the state of patients who were age 16 or greater and who had a congenital heart defect as the principle or secondary diagnosis. The ages of these patients ranged from 17 to 98 and 50% of them were 70 or greater. Ninety-three percent of these patients were managed in an acute care facility with an overall 6% mortality. Twenty-five percent of the in-hospital deaths during 1995 in this group of patients were age 64 or younger. Therefore, approximately 75% of the patients who died in the hospital with a primary or secondary diagnosis of congenital heart defect were older than age 65. Patients were admitted throughout the state for many reasons but many of the admission diagnoses included very common conditions encountered in the population without congenital defects. For example, congestive heart failure accounted for 661 admissions; infections, 378 admissions; acute myocardial infarction, 127 admissions; malignancy, 63 admissions; fractures, 46 admissions; psychiatric illness, 48 admissions; and diabetes, 26 admissions. Thus, as a state, Missouri has demonstrated

Congenital Heart Disease in Adults Specialty Centers in Missouri:

Kansas City
The Adult Congenital Heart Clinic
816-556-3053

Columbia
Congenital Heart Disease Clinic for Adults
573-882-2501

St. Louis
The Center for Adults with Congenital Heart Diseases
314-362-1613

The Adult Congenital Heart Disease Clinic
314-268-6574

that babies with congenital heart defects survive long enough to acquire "adult" diseases. Some of these adult patients will have fairly complex anatomy or residua of surgical care and can be quite unusual from the standpoint of physiology. This kind of complexity is fortunately uncommon but still requires experienced detailed care by professionals with understanding of the altered pathophysiology. As of this writing, I am not aware that any managed care organization or third party payor recognizes the need for special care of adults with complex congenital heart disease. Letters to five of the largest in the St. Louis area all went unanswered. One medical director called me to indicate that the patient picks his or her own physician and if specialized management is requested and the need documented, it would very likely be approved. This, of course, points out another problem in providing a system of health care that fits special needs. The patient also must understand the desirability of specialized care. I have often been amazed when interviewing a young adult with congenital heart disease how little they know of their own past health history. It is not unusual to see, for example, a young woman in the early weeks of pregnancy who knows she had cardiac surgery at an early age but is not aware of the defect or specifically what was done to palliate or correct it. Some of these patients have felt well and therefore had no follow-up for a number of years. These patients run a substantial risk of progression of the basic disease such as pulmonary hypertension, risk of bacterial endocarditis, risk of late development of arrhythmias or heart failure, and certainly a risk when they present for care with any of the long list of medical, surgical or obstetrical conditions alluded to above.

In closing, let me say, Missouri as a state has an excellent start to providing care to the growing numbers of adolescents and adults with congenital cardiovascular disease. Patients and families need thorough education. Care givers need an understanding of those conditions which require expert help and patient care organizations/payors need to recognize the long range benefits of specialized care for groups of patients with unique physiology. MoMed

The Author

Richard B. Whiting, MD, FACC, FACP is a Professor of Medicine at St. Louis University School of Medicine and Chairman of the Department of Internal Medicine and Cardiology at St. Mary's Health Center in St. Louis, Missouri. Dr. Whiting is a member of the International Society for Adult Congenital Cardiac Disease.

References:
1. Whiting RB. Letter to the Editor. *Missouri Medicine* 1995; 92:164.
2. Somerville J. Near Misses and Disasters in the Treatment of Grownup Congenital Heart Patients. *J Roy Soc Med* 1997; 90:124-127.

Thank You

The following letter was received by the Greene County Medical Society.

May 27, 1997

Dear Dr. Wolfe & the Society,

This past week I received a very pleasant surprise in the mail.

Enclosed was a letter from the President of the Missouri State Medical Association, a pamphlet concerning the Inauguration of the President of MSMA, and a 50-Year Physician Pin.

Although I knew of the forthcoming award ceremony at the Annual Meeting of the State Society, I had to decline attendance due to a prior committment. Thus, I was not expecting the above described recognition.

I am sincerely grateful!!

Please accept my most sincere thanks and my appreciation. Too, should it be possible to extend my gratitude to the State Association, I shall be appreciative.

Gratefully,

Richard L. Bartley, MD, (Ret.)

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References

References should be cited in numerical order in the text and arranged at the end of the article in the same order in which they are cited. The reference should give name of author, title of article, name of periodical, year, volume number, and page numbers.

Example:
1. Galata JF, Blue JM, Gaines RW. Osteochondroma of the scapula. *Missouri Medicine* 1995;92:95-97.

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A Physician Decries Managed Care Ethics

Thomas L. Holloway, MSMA Director of Government Relations

A Kentucky physician recently testified before the State Assembly in California that she caused a man's death by denying him treatment while serving as a medical coverage reviewer for a large HMO insurance company. "In the spring of 1987, as a physician, I caused the death of a man," confessed Linda Peeno, MD. "I have not been taken before any court of law or called to account for this in any professional or public forum," she said. "In fact, just the opposite occurred: I was rewarded for this."

Over the course of time that decision weighed heavily on Dr. Peeno's conscience. Even though her managed care training indoctrinated her to believe that she was not denying care, only denying payment, there was no avoiding the conclusion that she had abandoned the most basic of ethical standards: first do no harm.

Dr. Peeno's exposure to managed care was no brief encounter. She served as a medical reviewer for Humana's national market, left to become the medical director of a 35,000-member HMO, and ultimately served as a physician executive with Blue Cross/Blue Shield of Kentucky. Those experiences left Dr. Peeno with one inescapable opinion: her medical expertise was being used for the financial benefit of the organization, "often," she says, "at great harm, and potentially death, to some patients." Finding this conduct incongruous with her professional code of ethics as a physician, Dr. Peeno severed her ties with the business of health care and set off on a spiritual odyssey to better understand the complexities of managed care and the consequences of what she says are "serious ethic transgressions against individuals and society."

> **Dr. Peeno delivers a blistering polemic on managed care which she charges is "inherently unethical in its organization and operation."**

Since then Dr. Peeno has devoted her personal and professional life to concerns for medical and health care ethics, immersing herself in the study of ethics and philosophy, medical and health care law, health care organization and financing, and utilization and quality management. She draws some interesting conclusions.

In a compelling treatise prepared for the U.S. House of Representatives Subcommittee on Health and Environment, Dr. Peeno delivers a blistering polemic on managed care which she charges is "inherently unethical in its organization and operation."

Dr. Peeno methodically guides us through the basic principles of ethics and, through a series of provocative questions, offers a critical evaluation of how these codes of conduct are manifested (or not) in managed care. Do organizational missions embrace professional ethics, medical ethics, business ethics, and social ethics? How is the inherent conflict between allegiance to a corporate mission and the commitment to patient advocacy resolved? Is it possible that a physician, for financial reasons, could mislead a patient regarding prognosis to create the conditions for refusal by the patient? Is capitation inherently unethical in view of its goals and consequences (the withholding or denying of care)? Who is responsible when social ills are compounded by limited access to care and the neglect of medical needs?

She decries as unethical, several underlying presumptions commonly advanced by the managed care industry: that resources are scarce so rationing is necessary; that cost savings occur from cost reductions; that cost-containment measures, however harsh, are for the larger good of society; that medical decisions are made in managed care by physicians who are committed to the greater needs of health care; and that spiraling

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health care costs justify anything necessary to control the decision-making of physicians.

Dr. Peeno contends the systemic ethic problems in managed care require urgent correction in several areas. She offers several recommendations on how to reconcile, or at least mitigate the consequences of the conflicts of interest between the ethics of managed care and those of its tenuous partners, the business and medical communities. Among her proposed "corrections" for managed care:

- abandon all contractual arrangements which interfere or obstruct patient-physician relationships or otherwise encourage physicians to violate their primary ethical duty of beneficence in patient care;
- shift the burden of proof to the health plans to demonstrate they do not withhold or deny necessary care;
- require full disclosure of all financial arrangements with physicians whose clinical decisions will affect patient care;
- require full disclosure of cost-cutting strategies and other consumer information;
- develop an open grievance process which should include external assessments and independent judgement; and
- require all health plans to implement ethical guidelines and appoint ethics committees to address ethical conflicts arising from organizational decisions.

But Dr. Peeno is not without her critics. In light of the publicity surrounding her charges, Humana recently defended its commitment to providing quality health care for its members. As a germane example, Humana noted that in 1996 it approved 46 heart transplants and denied none.

Humana officials refused to debate Peeno's claims because they cannot properly investigate the facts of the case (she will not divulge the name of the patient) and because her story is 10 years old and "outside the context of current medical knowledge." They did, however, suggest there was a flaw in Dr. Peeno's recollection. It was pointed out that she was never a Humana employee, but a part-time consultant who served less than nine months and received no incentive compensation for any activity.

As diplomatic as it was, the Humana statement left me with the clear impression that they believe Dr. Peeno exaggerates her influence in the Humana decision-making process.

Whether or not you ultimately subscribe to Dr. Peeno's findings and conclusions, I think you'll find her work stimulating and provocative. Her report is available in its entirety from MSMA or can be located at http:/www.harp.org/peeno.htm. MoMed

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Membership: The 90s Bring About Change

Eileen Chalk, MSMA Alliance Vice President of Membership

As the AMA Alliance celebrates its 75th anniversary, the organization of some 50,000 strong, can be credited for major accomplishments in the area of legislation, medical education, and public health.

The Women's Auxiliary to the AMA was founded in 1922. A resolution, supported by the Texas Medical Association, stated the need for an organization that would "extend the aims of the medical profession through the wives of doctors to the various women's organizations which look to the advancement in health and education; also to assist in entertainment at all medical conventions and to promote acquaintanceship among doctor's families . . ." The Woman's Auxiliary was comprised of 24 women in 11 states. The changes over three quarters of a century, the sense of accomplishment, and the feeling of comraderie are what the Alliance celebrates.

For 75 years, the Auxiliary/Alliance has enjoyed many of the successes of a volunteer organization. By 1951, the Auxiliary membership reached a total of 57,000. "Assist in entertainment at all AMA conventions" was stricken from the original mission statement, and new focus of proactiveness became the Alliance's hallmark. In 1992, The Auxiliary changed its name to the AMA Alliance.

In recent years, the make-up of the Alliance has changed. Declining membership, intricacies of the medical families, and competing societies all add to the metamorphosis of the organization. The competition between other professional societies for their time and membership has also been a factor.

Although it is evident the Alliance has changed over the years . . . has it changed enough? What are our members looking for? In our need to become more active in legislation and public health have we become too active? Or do we need to change ourselves to allow everyone to be involved? "We have to evolve with our changing society . . . no longer can we sit back and watch what's happening and remain a viable organization," says Pattie Herlihy, 1996-97 AMA Alliance Membership Chair. "We are changing our basic philosophy: Traditionally we were a social organization and that's where our members wanted us to be, but in today's society you must have a cause, something that makes you stand out."

In 1991, the AMA Alliance joined the AMA Campaign Against Family Violence. In 1995, the AMA Alliance kicked off its first Stop America's Violence Everywhere (SAVE) program. "The need for more education and the understanding of family violence and the increased rates of health care costs resulting from violence has led to this national initiative," says Carol Jean DeFeo, President of the Medical Alliance of Metro Med of Greater Kansas City.

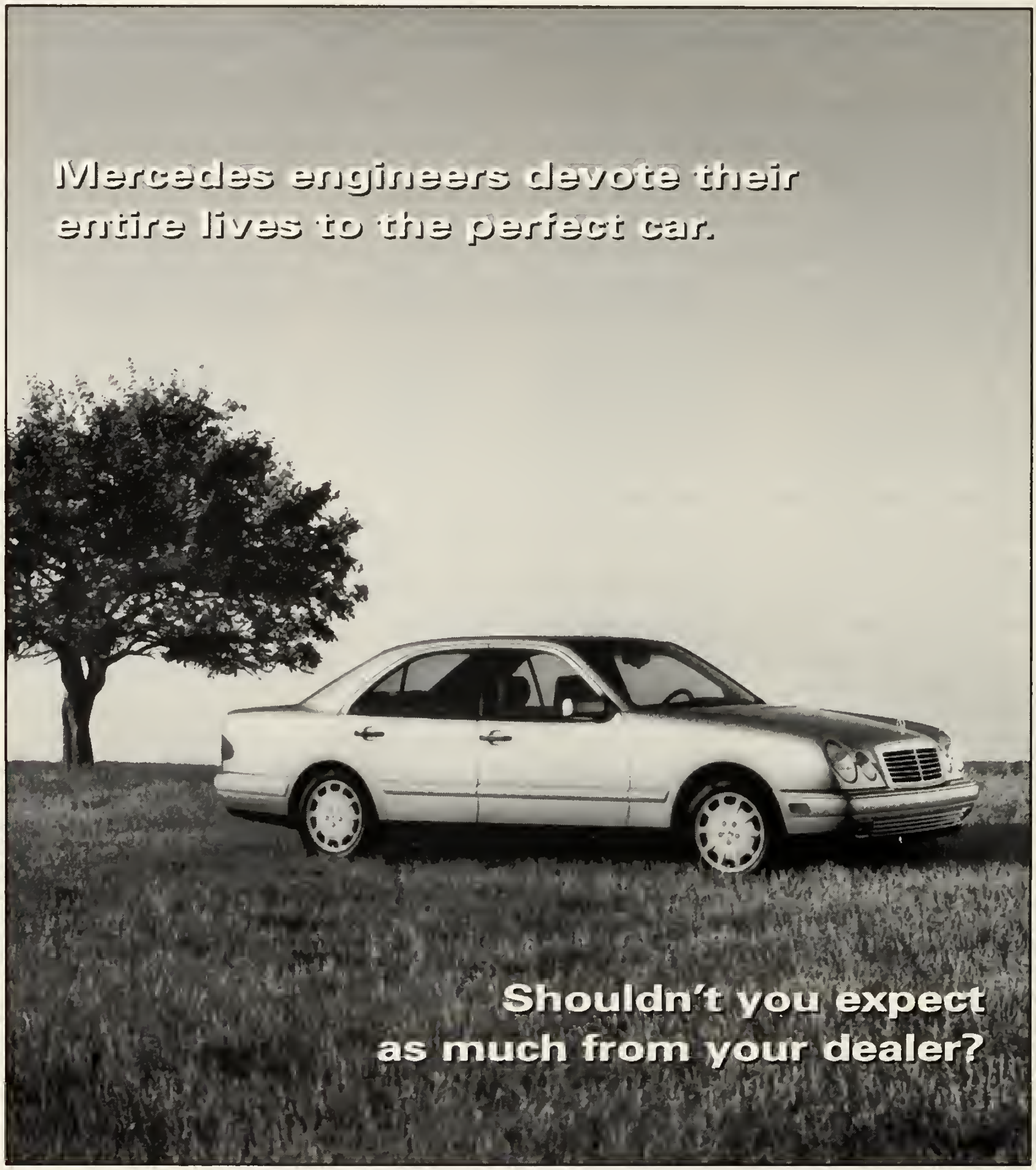
The following year in conjunction with the AMA, SAVE-A-Shelter was launched. This cooperative effort between Alliances and medical societies to adopt shelters helped victims reclaim their lives. The Alliance found that many people were eager to get involved with the SAVE project. "Our SAVE program has been a lifesaver for membership," says Pattie Herlihy.

As important as SAVE has been to membership, so is the recruitment of male spouses. No longer is it traditional for just the husband to be the physician. A survey performed earlier this year revealed the gender difference doesn't exist. The male spouses have the same concerns as the females. They cited spousal support, community service, social, public health, and legislative initiatives as the most important features of the Alliance. They also felt that the image of the Alliance should be changed from that of a social group to a community service organization.

Just as male spouses are important to membership, so are working physician spouses. The Alliance feels that if it positions itself well within the community as a service organization, it may also benefit from the support of the physician spouses who work outside the home.

"A unique situation exists among doctor's spouses. The demands on their ability are incalculable. Every hospital, school, and community organization looks to them for leadership not just membership and in regards to group projects," says DeFeo. "Therefore, the physician spouses' life becomes one of dedication to the service of others. However, they must not be guilty of neglecting the one area of service which can do the most for themselves and their spouses' profession: support of medicine."

It is the hope of the MSMA Alliance, that everyone be a member and support the family of medicine. **MoMed**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Two U.S. Supreme Court Decisions Give Control of Medical Ethics to the FTC

Public's Trust in Health Care Plummets

Arthur Gale, MD

American medicine faces an ethical crisis. In the past two decades, two U.S. Supreme Court decisions have changed medical ethics and the way physicians practice more radically than any other event since Hippocrates wrote his famous oath 2,400 years ago. Despite their importance, almost none of the nation's 700,000 physicians have even heard of these landmark decisions.

The first decision was the Goldfarb case in 1975. (*Missouri Medicine,* July 1997). In that case the Court ruled that medicine was no longer a learned profession. The practice of medicine was to be considered no differently from any other commercial activity and was henceforth subject to antitrust regulations which were to be administered mainly by the Federal Trade Commission (FTC).

The second Supreme Court case, FTC vs. the American Medical Association (AMA) concluded in 1980. In this decision the FTC found that ethical standards issued by the AMA were in violation of the Federal Trade Commission Act. By winning this case, the FTC gained control over the AMAs Council on Ethical and Judicial Affairs (CEJA) which is the AMA body which issues ethical opinions. By obtaining veto power over CEJA opinions, the FTC effectively neutralized AMA ethical opposition to HMOs. The FTC sponsored managed care revolution could then proceed smoothly and rapidly.

Shortly after the Goldfarb decision, the FTC wasted no time in exercising its new found control over organized medicine. It filed an antitrust suit against the AMA. The antitrust suit attacked the heart of the AMA - its code of ethics. The 1975 AMA code of ethics with its preamble is printed in Table 1. Even today it is difficult to find fault with any of its provisions.

The FTC basically attacked sections five and six. The FTC interpreted section five as prohibiting advertising and fee disclosure, and section six as prohibiting doctors from being employed on a contract basis (such as by an HMO).

Despite a valiant legal defense by the AMA, the courts unfortunately agreed with the FTC. The AMA lost in the lower courts. It lost in the Second Circuit Court of Appeals in a two to one decision. The U.S. Supreme Court in an equally divided 4-4 vote affirmed without comment the Federal Appeals Court decision. Justice Harry Blackmon recused himself because he had once represented the Mayo Clinic. Thus at both the Federal Appeals level and the Supreme Court level the AMA lost by just one vote.

The importance of these two decisions cannot be overestimated. The courts have essentially given the FTC the authority to ban any AMA ethical criticism of new forms of health care delivery such as HMOs. In addition the AMA has to write its code of ethics in such a way so that they are in compliance with the rules set by the FTC. The FTC monitors every recommendation and every policy issued by the CEJA.

The foremost example of the FTCs power over the AMA is an FTC order prohibiting CEJA from issuing restrictive ethical guidelines in the area of HMO financial incentives. Financial incentives are monetary bonuses paid to physicians for not ordering tests and procedures on patients and for not referring patients to specialists or to the hospital. It is obvious that financial incentives pit the interests of physicians against the interests of patients.

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Table 1 - AMA Principles of Ethics, 1975

1. PRINCIPLES OF MEDICAL ETHICS PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1: The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2: Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3: A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4: The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5: A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6: A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7: In the practice of medicine, a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8: A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9: A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10: The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Financial incentives are the heart of managed care. They are the fundamental means by which managed care achieves its savings. Until doctors were placed at financial risk over the past several years, HMOs did not lower medical costs. Therefore, an order restricting criticism of financial incentives is essentially an order restricting criticism of managed care. If CEJA went ahead anyway and criticized financial incentives in violation of the FTC order, its members and possibly the leadership of the AMA could be sent to jail.

AMA attorneys stated in court that the FTCs restraining order against CEJA violated the AMAs First Amendment freedom of speech rights. Two Federal Appeals Court judges in an unusual line of reasoning disagreed. They said that freedom of speech can be limited as when, for example, two competitors meet and discuss price fixing. But a CEJA advisory opinion on the ethics of financial incentives is hardly a conspiracy to fix prices and restrain trade. CEJA does possess moral authority, but it has no legal authority to compel doctors to do anything.

Of all people, the Federal Appeals Court and the U.S. Supreme Court should know that criticizing the government or a policy of the government is not a crime. The Supreme Court not too long ago rendered an opinion that under the First Amendment that its okay to burn the American flag. But in another opinion the Supreme Court can turn around and decide that it's not okay for the AMA to advise its members on the ethics of HMO financial incentives.

Where is the consistency?

By taking over control of its ethical standards, the FTC has essentially made the medical profession a vassal of the state. History teaches us that when medical ethics are controlled by the whims of the state and not by a higher professional and moral code great harm to human beings can occur. For example after World War II, at the Nuremberg Doctor's Trial, Allied prosecutors tried German physicians who had committed atrocities in the name of experimental medicine and the advancement of science. (*Journal of the American Medical Association*, Nov. 27, 1996). These doctors' actions were condoned and supported by the state. When the state takes control of medical ethics, the Hippocratic Oath, the AMA Code of Ethics, and all other codes of medical ethics become meaningless scraps of paper.

The AMA position in the FTC suit can be best summed up by referring to the dissenting opinion of Judge Mansfield of the 2nd Federal Circuit Court of Appeals. Mansfield pointed out that immediately after the Goldfarb decision, the AMA revised its *Opinions and Reports* and later adopted a new *Principles of Medical Ethics* in order to be in compliance with the FTC. The AMA removed the "offending" sections five and six from its *Principles of Ethics.* There was therefore no reason for the FTC to file the suit.

Judge Mansfield then describes the FTCs major purpose in filing the lawsuit as "pressing for its pound of flesh and beating a dead horse." The FTC, according to Mansfield, was basically letting the AMA know who was boss in the area of medical ethics.

Mansfield goes on to cite the pretrial prejudicial statements by the then director of the FTC, Michael Pertschuk. These statements illustrate the cynical opinion of the medical profession held by the movers and the shakers at the FTC. They also give insight into the goals of the FTC.

Pertchuk's stated, "While it would probably be excessive to say that the fox [the medical profession] is guarding the chicken coop, it is undeniable that a great many critical judgments in this field are being made by people with a direct economic stake in particular outcomes......"

Thus any criticism of HMO financial incentives on ethical grounds is dismissed by the FTC as a rationalization for protecting doctors' pocketbooks. This statement also justifies the FTCs lofty vision of its "mission" as elitist social engineers whose goal is to restructure American health care to better serve the needs of consumers.

But the FTC neglected to ask the American public its opinion of HMOs which employ financial incentives. As a result it should come as no surprise that the public is not very happy with the results of the FTCs social engineering. Evidence is mounting that under managed care, consumers are losing their trust in health care.

I discussed these matters with an FTC antitrust attorney at a recent medical meeting.

I pointed out that:

1) The media across the nation bashes managed care on a fairly regular basis.
2) Independent public opinion polls rank managed care very low - just above the tobacco industry in one survey.
3) At a Missouri legislative committee hearing in 1996, more than 150 persons gave 2,500 pages of testimony against managed care companies in attempting to get a bill passed which would regulate the excesses of managed care.
4) The legal system and the courts are successfully attacking and destroying the credibility of financial incentives.

I then asked the antitrust attorney if the FTC was satisfied with the results of its reengineering the American health care system. He did not dispute the points that I had brought up, but his answer, to say the least, was disappointing. His response was that, "the market was evolving."

This is a standard bureaucratic response. If plans don't work out as expected, take no responsibility and show no remorse.

In downtown St. Louis stands a stately pre-Civil War courthouse. Nestled among modern high-rises the Old Courthouse, as it is affectionately called, seems strangely out of place. But the Old Courthouse is more than a nostalgic reminder of a bygone period. It stands as a reminder - actually a monument to the fallibility of the U.S. Supreme Court. For in this courthouse, the infamous Dred Scott case took place - a case in which the Supreme Court ultimately declared that a human being was property.

There have been many bad decisions by the Supreme Court before and since Dred Scott. The Dred Scott case was eventually reversed. Most of the other bad Supreme Court decisions which are not high profile such as Goldfarb and FTC vs. AMA will likely remain on the books forever.

But there is in our democratic society a court even higher than the Supreme Court. It is called the court of public opinion. The public, not the FTC and not the courts, will render the final opinion on the ethics of the U.S. health care system of the future. The public will make a choice either of FTC sponsored ethics characterized by financial incentives, physician guile, and patient mistrust; or the public will choose a health care system based upon more than 2,000 years of professional ethics, characterized by openness and honesty where physicians practice as patient advocates. **MoMed**

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Pyramid Schemes and Ethics

Don G. Fortin, MD

Name one specialty that does not feel the effect of managed care on the private practice of medicine, whether it be a matter of finances, lifestyle, or most importantly, patient care. Indeed managed care, Medicare regulations and potential fines, and RBRVS have elevated our stress levels, prompted early retirements, and in many cases redirected careers. Each year I spend more and more time dealing with the paperwork relevant to managed patient care, needless to say time away from the essence of my practice, patient care itself. This trend has simply become an undesirable ingredient of our care of the patient.

Is it my imagination or a reality . . . the dull, disheartened expressions on my colleagues' faces? Must I accept that the prevailing topic among my colleagues appears to be what will be the best strategy against the next obstacle to confront our practices?

Has there not already been enough of an assault on our profession and professionalism over the past twenty years? We now have to deal with dissension within our numbers by virtue of actions that are contrary to professionalism and ethics. What might this question of dissension be?

Like most of us, I am regularly confronted with offers of or introductions to business or investment opportunities. Presumably we, as physicians, are in the "unique" position to take advantage of such opportunities. Most, if not all, in reality tend to be most opportune for those offering such "schemes" rather than we who are preyed upon. For some inexplicable reason (or perhaps more obvious) I have experienced a recent surge in such solicitations but with an alarming slant.

These "unique" solicitations have come from within our profession! With aggressive promotional methods (audio tapes, group seminars, one-on-one solicitation) these groups promote the marketing of products **for profit** to be sold in our offices. Some of these "opportunities" involve products unrelated to health care or only tangentially so. Further inquiry reveals that an alarming number of medical doctors (along with allied health professionals, chiropractors, podiatrists, accountants, nurses, pharmacists, etc.) are already heavily involved in these endeavors, some for a number of years. Needless to say, these products are only available through distribution. These multi-level marketing" or "network marketing" opportunities are, in fact, **pyramid** schemes.

Are we at a point in time when some would have us believe it appropriate to distribute **Amway** in a medical office? The ploy of this activity is not only the profitability of the distribution of products, but also the availability of other **merchandise** for purchase by the distributor through **Amway** at **substantial savings.**

A more aggressive concern, however, is **Rexall Showcase International**, a soluble fiber and vitamin-based product, **Bios Life 2**, is promoted for the treatment of hypercholesterolemia, weight loss, reduction of insulin requirements and the sequela of diabetes. This particular product is promoted for its effectiveness and food-based nature. When compared to the newer prescriptive anti-hypercholesterolemic drugs, the company claims virtually **no harmful side effects**, although one of this product's main ingredients is a form of guar gum. Guar gum is under FDA scrutiny and reports the association of guar gum with small bowel obstruction. Other beneficial effects are reported, supported by endless testimonials expressed with cult-like zeal. The company markets a full line of other natural-based products and pharmaceuticals, many that are commercially available at a fraction of Rexall's price. The subtlety of the matter is that the patient need only telephone an order, giving the distributor's identification number. In so doing, a profit of **20-**

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50% over wholesale cost is credited to the "physician" distributor.

Let me be clear about one thing. I am neither an idealist nor a purist in my professional behavior. But I did enter the practice of medicine for humanitarian reasons as most of us did considering the personal sacrifices. I also entered this profession fully realizing the financial security it would provide for my family and me (albeit a Vanderbilt I would never become). And I entered medicine agreeing to subscribe to and commit my behavior to the principles of the **Hippocratic oath**, literally and figuratively, and the **ethics** of our profession.

These revelations left me uneasy so consequently I investigated the matter. Mind you I have no qualm with whatever a colleague chooses to do **outside the environment of medicine**, provided it be legal. Product viability aside, the bottom line remains: **such activity is in violation of the AMA code of ethics!**

Section 8.06 Drugs and Devices: Prescribing

1) A physician should not be influenced in the prescribing of drugs, devices, or appliances by a direct or indirect financial interest in a pharmaceutical firm or other supplier. Whether the firm is a manufacturer distributor, wholesaler, or repackager of the products involved is immaterial.

Then, to, this matter of **due-diligence**, a concept which is at the core of the Hippocratic oath. Due diligence, in my mind, necessitates researching product alternatives, many costing substantially less than these products. As treating medical physicians, I believe we are obligated to inform our patients of all treatment alternatives including the relative cost factors.

The span of involvement on the medical profession is disturbing. Alarming is the blatancy of the attitudes expressed in the promotional testimonials, for instance the statement that failure to distribute these products to patients should be regarded as "unethical." There is blatant disregard for the scientific method by these anecdotal experiences. In argument of product validity, was the manufacturer ever approached as to the commercial availability of its products for the general good of our patients rather than selective distribution, in particular through our offices? Has it ever occurred to the disturbing medical physician to arrange availability of the product from some other source thus eliminating oneself from the profit equation? This does not speak well for the other professionals who distribute these products in violation of their profession's code of ethics.

What disheartening revelation in this the sesquicentennial of the AMA's **Code of Ethics**! How dare our colleagues who would direct us toward this street peddling office conduct, compromise our ethical code for profitability, and jeopardize their professionalism and that of their colleagues!

Regardless of the current health care environment, we hardly need this dilemma! MoMed

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Missouri Combined Regional Meeting

October 17, 18, and 19, 1997
Lodge of the Four Seasons • Lake Ozark, Missouri

16 hours CME

Friday, October 17

SESSION I: ALLERGY FOR THE INTERNIST

8:30am	Rhinitis-*Jean A. Chapman, MD, MACP*
9:10	Sinusitis-*Raymond G. Slavin, MD, FACP*
9:50	Break
10:15	Asthma-*Mark S. Dykewicz, MD, FACP*
10:55	Anaphylaxis-*Phillip L. Lieberman, MD, FACP*
11:35	Questions and Answers
Noon	Adjourn

SESSION II: RHEUMATOLOGY FOR THE INTERNIST

1:30pm	Studies in Connective Tissue Disease- *Terry L. Moore, MD, FACP*
2:10	Rheumatoid Arthritis-*Peri H. Pepmueller, MD*
2:50	Break
3:10	Anti-Phospholipid Syndrome- *Kent A. Huston, MD, FACP*
3:50	Systematic Lupus Erythematosus- *Sara E. Walker, MD, MACP*
4:30	Questions and Answers
5:00	Adjourn

Saturday, October 18

8:00am	MSIM President's Address- *James T. Rogers, MD, FACP*

SESSION III: SOCIOECONOMIC SESSION

8:30	Use of Physician Extenders in Clinical Practice- *Robert C. McCartney, MD, FACP*
9:15	Re-Envisioning Health Care in America-*Scott Croft*
10:15	Break
10:35	Re-Envisioning Health Care in America (cont.)
Noon	MSIM 40th Anniversary Celebration
2:00	Adjourn
6:30	Reception and Awards Dinner

Sunday, October 19

SESSION IV: SCIENTIFIC SESSION

8:15am	Update in the Drug Therapy of Diabetes- *Arshag D. Mooradian, MD*
9:00	Dermatology Update for Internists- *Ronald W. Swinfard, MD*
9:45	Shared Responsibilities: A Synergistic Relationship Between Generalists and Subspecialists in Patient Care-*Oscar E. Edwards, MD, FACP*
10:15	Break
10:30	Current Therapy of Osteoporosis- *Lorraine A. Fitzpatrick, MD, FACP*
11:15	Recent Advances in the Evaluation and Treatment of Migrane Headaches-*Christina M. Burch, MD*
Noon	Adjourn

Learning Objectives:

At the conclusion of this activity, the participant will be able to:

1. Utilize new information in allergy regarding the clinical syndromes of rhinitis, sinusitis, asthma, and anaphylaxis.
2. Develop evaluation and management strategies for the anti-phospholipid syndrome, systematic lupus erythematosus, and laboratory tests for connective tissue disease.
3. Anticipate impending changes in the structure of medical care delivery, including physician extenders and computerized medical records.
4. Update knowledge in the clinical areas of dermatology, diabetes mellitus, osteoporosis, and headaches.

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General Information

Session registration fees are as follows:

Allergy and Rheumatology Update (Fri. only)	$85
Traditional Meeting (Sat. and Sun.)	$50
All Sessions	$100
Reception and Awards Dinner	$35

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Missouri Teens Speak Out on Lighting Up!

Mary Vest Mason, MD; Resident Physician Section Councilor;
AMA Resident Physician Section Member-At-Large

In 1997, we find ourselves three years away from the year 2000; three years away from the American Medical Association's goal of a smoke-free America. Despite the wonderful efforts of the AMA, the American Cancer Society, the American Lung Association, and many other organizations, currently 20% of the teens are smokers and 80% have tried smoking at least once. Even more alarming, 60% of teen smokers have tried to stop, with only 1.2% succeeding.

School-aged kids and teens are bombarded with the facts. They know smoking leads to emphysema, heart disease, and cancer of the lung, mouth, throat, pancreas, cervix, kidney, and bladder. Then they turn on the television, open a magazine, or look up at a billboard and see old Joe Camel spreading the message that smoking is cool and everybody is doing it.

The Missouri State Medical Association - Resident Physician Section wanted to join the fight for a smoke-free America. Our idea was simple. In order to make teens, the most vulnerable group to pro-smoking propaganda, really think about the pros and cons of smoking, the Resident Physician Section sponsored an essay contest entitled "Why I Shouldn't Smoke Cigarettes." For a target audience, we turned to the Junior League of St. Louis' project TOTAL (Teen Opportunities To Achieve in Life), a school-based community collaborative project for middle and high school teens in the Ferguson-Florissant and Jennings School Districts in St. Louis, MO.

Resident physicians, armed with smoking facts, posters, and snacks, visited the 174 seventh through tenth grade students enrolled in the TOTAL after-school program. These teen participants were shocked when they figured out how many CDs or pizzas they could buy with the $800 an average smoker spends per year on cigarettes. With looks of disgust, they examined a photograph of a lung filled with cancerous cells. This was the inspiration they needed to write their essays on why they choose to be nonsmokers.

With a $500 AMA Policy Promotion Grant and financial support from the Junior League of St. Louis, a total of twelve 35mm cameras have been awarded to our winners.

Derek Stricker, an 8th grade student at Jennings Middle School, is one of our grand prize winners. Derck's essay provides insight into the peer pressure he faces when making the decision to light up a cigarette, and his personal reasons for saying no.

Why I Shouldn't Smoke Cigarettes

by Derek Stricker

Smoking is something I feel strongly about because it is addictive, terrible for your health, and can kill you. I feel very uncomfortable around people, who aren't bad people, who smoke. The fact is that second-hand smoke can be much worse for you than it is for the smoker. So one reason why it's not good to smoke, is because it is bad for others. It puts tar in your lungs, yellows your teeth, makes you smell terrible, can give you lung disease...must I go on?!

When I see people smoking, I think, why? Why do they do this to themselves? Yes I know it is addictive, but why do people start in the first place? Some do it to be cool or popular; which I think is the lowest way to get friends. You don't make real friends this way, you make true friends by being YOURSELF, not someone you aren't.

Cigarette smoke also causes a large amount of pollution. The smoke can contribute to global warming, by trapping heat. It pollutes the air along with things like cars and industries, causing more diseases, like asthma. Also, almost half of the litter I see is cigarette butts. So it affects everyone.

The diseases, such as lung cancer, are hard, if not impossible to recover from. They (diseases) make life miserable and painful. Those reasons why you started smoking are just not worth it. My mother has had lung surgery, (for a different reason) and she, as can my whole family, tell you how unpleasant it was.

So, for the people, for the environment, for you, don't start!

Our second grand prize winner is McClure North High School student Bob Dickhans. This 9th grader's essay deals with his negative experiences with smoking and why these have influenced his decision to be a non-smoker.

Why I Shouldn't Smoke Cigarettes

by Bob Dickhans

I have many reasons for not smoking, one of which is cancer, Most of the deaths in the United States are from smoking. Lung cancer is a very serious cancer. Cancer is sort of like acid; it burns through your organs.

My dad told me a story of why he does not smoke anymore. It goes something like this: I was about one year old and my sister was about two and a half. My dad was smoking, then my sister came over and tried to grab his cigarette. Ever since then he has not smoked. So my point here is that the smoke may hurt you but it also might hurt other people or even little kids. My step-sister has a two-year-old child with asthma. My step-sister is always smoking and this is bad for the child's asthma. If a person has asthma, being around smoke is very dangerous and they could die.

Another bad problem about smoking is second-hand smoke. Second-hand smoking is when you are around someone smoking and you get smoke in your lungs. Some second-hand smokers can get lung cancer and even die. Before you smoke give this a thought; do you want your friends, relatives, or anyone else you know to die?

Cigarettes make pollution to make the cases, packs, paper, and filters. Then when you smoke them there is more pollution. Pollution is bad because it's destroying the ozone layer. The ozone helps protect your skin from the sun. If the ozone was gone, then you could get skin cancer or other diseases.

The reasons why I do not smoke are: I am not old enough, I do not want cancer; I do not want to hurt others with my second-hand smoke. I do not smoke because I hate the smell and taste of smoke. Just because your friends smoke and say it is cool does not mean you should do the same. Listen to these reasons and you might actually decide not to smoke either.

After reading the thought provoking words of our youth, the members of the Missouri Resident Physician Section are encouraged that our country may be heading down the right path toward a smoke-free America, maybe not by the year 2000, but in the not so distant future.

Ninth grade McClure North High School student Tara Bellamy, like so many other teenagers, knows the dangers of tobacco and chooses to be a nonsmoker, which she displays in the following poem. Maybe America's smoking adults could learn a lesson or two from teens like Tara, Derek and Bob. MoMed

If I Smoke

by Tara Bellamy

If I smoke, I choke.
If I think, I stink.
Cigarettes turn you lungs black,
then you'll have a heart attack.

If you get hooked, your brain will cook.
I tried, but I couldn't choke,
and that's why I shouldn't smoke.

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Not Guilty by Reason of Insanity: What Happens After Acquittal?

Richard Wiener, PhD, MLS and Danny Wedding, PhD, MPH

Most Missouri criminal lawyers and many physicians are familiar with the defense, not guilty by reason of mental disease or defect (NGRI), provided for in Missouri statute [Mo. Rev. Stat. Sec. 552.030.1 (1996)]. Accordingly "a person is not responsible for criminal conduct if, at the time of such conduct, as a result of mental disease or defect he was incapable of knowing and appreciating the nature, quality, or wrongfulness of his conduct." A defendant who is acquitted of charges because he or she was suffering from a mental disease or defect is..."committed to the director of the department of mental health for custody...and care in a state mental health ...facility." [Mo. Rev. Stat. Sec. 552.040.2 (1996)]. The client remains in custody of the Department of Mental Health until he/she can show by "clear and convincing evidence" that he/she is not likely to be dangerous to others while on conditional release. [Mo. Rev. Stat. Sec. 552.040.12 (1996)].

Although most physicians are aware of the law's provisions for the mentally ill, some may not know very much about the treatment experience of defendants who are committed to the Department of Mental Health when they suffer from a mental disease or defect. Even fewer are knowledgeable about the facilities that are available for treatment of offenders who show anti-social behavior patterns. Among the lay public (and perhaps among some physicians as well) there exists a common perception that a client who is spared criminal prosecution because of a NGRI defense will be assigned to a hospital ward in which he/she will receive haphazard treatment, participate in unstructured activities, and lounge in comfortable surroundings.

In 1996 the Missouri Institute of Mental Health evaluated the Social Responsibility Ward at Saint Louis State Hospital. This program is designed to treat clients who not only suffer from serious forms of mental illness, but who also engage in severe anti-social conduct. Some of these clients have been judged to be not guilty by reason of insanity. Treatment involves a highly structured environment designed with the explicit purpose of training clients to take full responsibility for their future actions.

The treatment philosophy on the Social Responsibility Ward is based upon a cognitive behavior therapy model. According to this model, the purpose of treatment is to alter cognitive processes that interfere with clients' abilities to function outside the hospital environment. The treatment model assumes that clients hold cognitive schemata (factual and emotional memory structures) that are maladaptive and that produce maladaptive views of the world. The purpose of therapy is to restructure the clients' cognitive schemata, in turn making the men and women who participate more functional. Program staff teach the clients to seek accurate and objective interpersonal information and then to apply social problem solving skills before engaging in any explicit behaviors. The staff challenge the habitual thinking that clients automatically invoke. Dysfunctional cognitions are replaced with controlled and well-reasoned thought patterns. For example, clients are taught they can not always obtain what they want when they want it. In addition, the staff instruct the clients in basic survival proficiencies to help the clients overcome their fundamental deficits in literacy, social skills, work skills, and time management.

An interdisciplinary team consisting of a psychiatrist, psychologists, social workers, nurses, and aides writes a preliminary Individual Treatment Plan (ITP) for each client within 10 days of hospitalization. The team reviews and finalizes each client's treatment plan within 30 days and revises the plan at the end of every 60-day period during the first year, and every 90-day

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period in subsequent years. The ITP identifies the client's characterological problems, outlines specific plans to treat the clients' diagnosed mental disorders, outlines appropriate methods to treat substance abuse problems, and catalogues the issues that require attention in group therapy sessions for each individual client. The treatment team identifies the most severe problems of particular clients after referring to a problem checklist. The staff selects attainable and measurable goals for each client and examines the client's record to determine if the client is making progress. If little or no progress is indicated, the group makes alterations in the client's treatment plan.

Two central treatment components are used to assist clients in attaining their treatment goals: group therapy and milieu therapy. In group therapy, mental health care workers provide a structured opportunity for clients to practice coping with their problems. The mental health care workers give "homework assignments" such as requiring clients to practice certain types of cognitive skills. The greatest impact, however, occurs in milieu therapy following ward encounters in which the staff correct the cognitive errors of clients. Errors of thinking ultimately lead clients into situations in which they disobey ward structure and policy. These situations provide *in vivo* opportunities to teach clients more adaptive ways of solving problems, resolving conflicts, and coming to terms with authority.

Two of the core group therapy sessions in which men and women on the Social Responsibility Ward are required to participate are Responsibility Therapy Group (RTG) and Dialectical Behavioral Therapy (DBT). The goal of RTG is to examine each client's thoughts, feelings, and behaviors and to correct thinking errors that contribute to poor problem solving. The group also tries to increase the clients' interpersonal empathy levels and improve the social skills that the clients need for responsible living. The group uses cognitive behavioral therapy to help the clients take charge of and responsibility for their own lives. It assists clients to recognize their cognitive distortions and change them. This is accomplished by helping clients understand how their irrational thoughts give rise to behavior that leads them into conflict with society. During group therapy sessions clients learn that many of these automatic thoughts have become ingrained over time. Some of these irrational thoughts give rise to perceptions, attitudes, emotions, and behaviors that are harmful (i.e., anger and aggression).

In the DBT, clients learn how their ingrained and irrational beliefs produce harmful behavior. The emphasis of this group is on teaching clients to think about the consequences of their actions before they act and get into trouble. Thus, the major purpose of the group is to help clients control impulsive behavior. The group also teaches skills to clients that will enable them to control their own affective responses and gain control over maladaptive behavior patterns. RTG and DBT force clients to confront their own habitual thought patterns and to modify their cognitions to produce more functional behavior. The group sessions are often very uncomfortable for clients because they are forced to face their own dysfunctional thoughts and feelings and plan alternative procedures for resolving interpersonal conflicts.

It is important to emphasize that clients participating in DBT are taught to generate *proactive* and *prosocial* thoughts and behaviors to replace their previous maladaptive thoughts and behaviors. The object is for clients to gain control of their affective responses and to gain control over their own behavior pattern by learning new skills and thought patterns to replace or counter previous maladaptive thoughts and behaviors.

The ward environment encourages the use of responsibility therapy and the accompanying problem solving skills so clients learn to apply these principles on a moment by moment basis. It is the goal of the treatment model to immerse the clients in the principles and process of socially responsible thinking. The staff and the clients apply the principles to assist in solving problems, recognizing errors of thought, and identifying problem feelings and behaviors during the normal ward activities outside of the group setting. For example, when one staff member observed a client smoking in an inappropriate area, the staff member recorded the infraction and then discussed the violation with the client. The staff member pointed out the negative consequences of similar (and more egregious) rule violations in the client's life and discussed alternative actions that client could engage in without disobeying ward regulations. It is these daily interventions that are most likely to change the client's conduct.

Patients are rewarded for meeting specific criteria at each of four levels of increasing ward responsibility. Patients must achieve each of the criteria for four weeks in order to advance to the next level. Progressive levels reward the clients with greater privileges. The criteria at levels two, three, and four become progressively more demanding. Patients who fail to meet level advancement requirements or who violate ward rules and policies fail to advance to the next level or return to an earlier level. The goal of the level system is to assist the clients to raise their overall level of functioning so they are able to conduct themselves appropriately in society. The level system reinforces the enactment of daily activities that the clients will need to master in order to live outside the hospital (e.g., getting out of bed, personal hygiene, and appropriate social interaction). The level system also helps the staff maintain social and behavioral control of clients. Patients who work hard in group sessions and try to take advantage of the cognitive behavioral model work their way up the level system gaining more privileges and responsibilities. Patients who fail to make significant progress on the ward face an uncomfortable existence with little hope for future release or increased independence on the ward. It is only after clients demonstrate their increased levels of responsibility that the hospital staff respond by offering the clients greater levels of personal freedom. There are many clients who do not reach that level of success and spend all of their time on the hospital ward in a privilege-limited environment. These clients are unlikely to be released from the unit, and are typically retained under close supervision on the hospital ward.

The purpose of the Social Responsibility Ward is to retrain clients to think about the world in a more responsible and rational manner. It is expected that such cognitive retooling will result in better functioning human beings who will eventually be able to function in an open environment and live their lives in a socially acceptable manner. MoMed

The Authors

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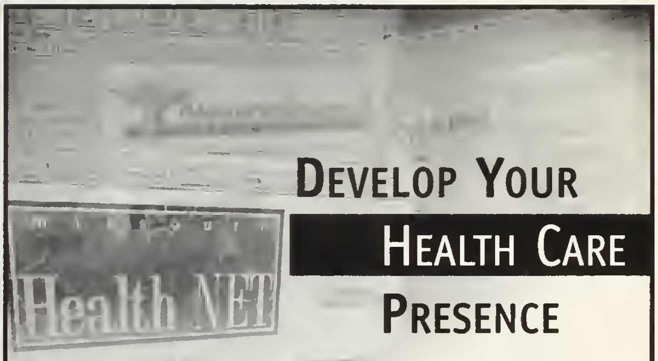

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HCFA Draft Rule Proposes Changes in the Medicare Beneficiary Complaint Process

Walter F. Davisson, MD, MPCRF Board Member
Patrick J. Mills, MBA, CPA, MSMA Director of Health Care Finance

The Health Care Financing Administration (HCFA) is undergoing a major restructuring. HCFA as a beneficiary-centered purchaser will use its market influence to obtain the "best value" for beneficiaries.[1]

In November 1995, the U.S. Department of Health and Human Services, Office of the Inspector General (OIG) issued a report entitled "The Beneficiary Complaint Process of the Medicare Peer Review Organizations (PRO)" which recommended that HCFA work with the PROs to:

❶ Change the regulations governing the confidentiality of the PRO responses to Medicare complainants;

❷ Identify ways to streamline the complaint process; and

❸ Identify cost-effective ways to enhance Medicare beneficiaries awareness of PROs and the complaint process.

HCFA then established the Medicare Beneficiary Complaint Task Force which made specific recommendations regarding the streamlining of the complaint process. The Task Force also recommended no longer requiring the PRO to obtain physician consent prior to disclosing review conclusions to the complainant.

The draft rule, which has not yet been published in the Federal Register, lacks any strengthening of the due process proceedings accorded physicians.

Missouri State Medical Association (MSMA) board members of the Missouri Patient Care Review Foundation (MPCRF) - the PRO for Missouri, initiated a resolution to communicate to HCFA, the American Medical Association (AMA), the American Osteopathic Association and other PROs, MPCRFs position that PROs should not disclose beneficiary complaint findings without the consent of the physician.

While physicians are not opposed to giving beneficiaries information; communication to complainants as to whether the PRO found fault, regardless of whether the physician consents, is not supported by either the AMA or the MSMA. The draft rule, which has not yet been published in the Federal Register, lacks any strengthening of the due process proceedings accorded physicians.

Most notable in HCFAs proposed change is how it compares to the PROs current focus on continuous quality improvement (CQI). In sharp contrast to the current educational approach, HCFAs draft rule allowing communication to the complainant without physician permission will re-establish the PRO as the punitive entity it was before becoming the quality improvement organization it is today.

"Little imagination is needed to see how communication between physicians and the PROs will deteriorate if the PROs begin delivering bad news," said Turner Minnigerode, MD, MPCRF Chairman. "Communication is more important now that the complaint process has been streamlined."

The Task Force strategy for improving the complaint process has been accomplished through

Continued on page 572

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revisions of the Medicare PRO Manual. The time allowed for PROs to complete reviews was reduced substantially - thirty days to twenty days.

> **"Communication is more important now that the complaint process has been streamlined."**
>
> *Turner Minnigerode, MD*
> *Chairman, MPCRF*

AMA has communicated to HCFA the need to monitor the appropriateness of shortening the complaint process. The Social Security Act has specified that before a PRO concludes that the quality of service does not meet professionally recognized standards of health care, the physician must be provided with reasonable notice and opportunity for discussion. The reduced time diminishes the due process available to physicians.

Watch MSMAs *Progress Notes* for more information about HCFAs draft rule. If HCFA proceeds with publishing it as a draft rule in the Federal Register, then physicians should comment to express their displeasure. MoMed

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Exposure to Lead Mining Waste: A Risk Factor for Elevated Blood Lead Levels in Missouri Children

Ana Maria Murgueytio, MD, MPH
Gregory Evans, PhD, MPH

Missouri is the number one lead mining state in the United States. Although the public health community has been aware of the risk of lead exposure from these sites, it has been of only minor concern because of the common belief that lead, primarily in the form of lead sulfate, is not readily biologically available and, therefore, possesses no risk or only minor risk to the population.

A publication from the Centers for Disease Control and Prevention (CDC), *Preventing Lead Poisoning in Young Children* (1991), indicated that significant adverse effects of lead exposure in children have been documented at levels previously believed to be safe. The CDC, therefore, revised the 1985 level of concern of 25µg/dl downward to 10µg/dl and recommend that only blood lead tests be used. Earlier tests to identify children with elevated blood lead levels (erythrocyte protoporphyrin) were not sensitive to blood lead levels below 25µg/dl and, consequently, children with blood lead levels below this threshold would have gone unnoticed.

This new evidence of adverse health effects at low blood lead levels along with antidotal evidence from local health departments that a number of children living around abandoned lead mines were presenting with blood lead levels between 10 and 25µg/dl, stimulated our interest to determine the prevalence of blood lead levels above 10µg/dl in a mining area close to Joplin, Missouri in Jasper County.

The Jasper County Missouri Superfund Site is a portion of the old Tri-State Mining District of Missouri, Kansas, and Arkansas. From the 1840s through the Civil War years, more than 200 widely dispersed primitive log lead smelting furnaces were operated in this area. Mine production in the Missouri portion went on to reach its peak in 1916 when more than 123 million rock-tons were processed to yield approximately 304 thousand tons of zinc concentrates and 41 tons of lead concentrates. The site is generally characterized by extensive surface land disturbances and piles of mine waste that resulted from the mining operations.

Mine waste has been used as railroad ballast, road materials, and aggregates in asphalt paving and concrete. Sands and smaller sizes have been used for, abrasives, roofing granules, pipe coatings, filter sands, and even in children's sandboxes and play areas. Mine waste also is blown into the homes of residents in the area and is mixed with other materials originating inside and outside the home, including paint flakes, to form a mixture referred to as "dust." The waste contains differing concentrations of lead depending upon the type of smelting procedures used.

Methods

Individuals were randomly selected and stratified into three age groups, 6 through 71 months (children), 6 through 14 years (youth), and 15 through 44 years (adults).

A control area was chosen to be socioeconomically similar, geographically close, but physically outside the Superfund and lead mining area. It included parts of Neosho and all of Goodman, Missouri. Participants were interviewed and blood was collected. In a subsample of homes, environmental measurements were also obtained. There were 412 persons in the mining group and 283 in the control group.

Results

The table presents blood lead and environmental data. All environmental measurements were higher in the study group compared to the controls. Lead in soil was more than six times higher in

Continued on page 574

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the study area compared to the control area and lead in dust and interior paint was three times higher.

Average blood lead levels in children were almost twice as high in study area children compared to controls. Average blood leads were also significantly higher for youths and adults.

In the study group, 14% of the children had blood lead levels greater than 10µg/dl (the level of concern indicated by the CDC) and 5% had levels greater than 15µg/dl. None of the control children had blood lead levels that were greater than 10µg/dl. Children with elevated blood lead levels did not have other known sources of lead exposure. Only one youth in the control group and one adult in the study group had blood lead levels greater than 10µg/dl.

Conclusion

Children and youth living in the Jasper County Superfund Site where soil is contaminated with lead from mining and smelting operations have a higher prevalence of elevated blood lead levels compared to children living in an area without soil contamination. The data suggests that this increased prevalence of elevated blood lead levels is due to a combination of soil lead from mining and smelting operations and other sources of lead, such as household lead paint.

Physicians with patients that live or work in areas of lead mining or in areas in close proximity to lead mining waste should consider testing children for blood lead levels. This is even more important if the children have other risk factors such as living in homes built before 1960, living in homes with deteriorating lead paint, or having a parent working in an occupation with lead exposure. MoMed

The Authors

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Comparison of Blood Lead and Environmental Data

Variable	Lead Mining Group Mean ± SD (n)	Control Group Mean ± SD (n)	p-value[1]
Environmental			
Lead Dust, ppm	608 ± 1551 (125)	209 ± 408 (26)	.006
Lead Water, ppb	2.62 ± 3.60 (125)	2.12 ± 0.42 (26)	.438
Lead Paint, mg/c2	1.38 ± 1.65 (121)	0.412 ± 0.23 (26)	.001
Lead Soil, ppm	599 ± 735 (125)	91.1 ± 112 (26)	.001
Children 6 through 71 Months of Age			
Blood Lead µg/dl	6.25 ± 4.86 (225)	3.59 ± 1.88 (128)	.001
% Greater than 10µg/dl	13%	0%	.001
Youth 6 through 14 Years of Age			
Blood Lead, µg/dl	3.61 ± 1.97 (115)	2.46 ± 2.24 (94)	.001
% Greater than 10 µg/dl	0%	1%	NC[2]
Adult 15 through 44 Years of Age			
Blood Lead, µg/dl	3.44 ± 4.59 (51)	2.22 ± 1.35 (49)	.052
% Greater than 10 µg/dl	2%	0%	NC

1. P-values from t-test, two tailed for means and Fisher's Exact test for proportions
2. Not calculated because of small numbers

Relax The Back Store

Emergency Medicine Quiz #1

Mark T. Steele, MD
Department of Emergency Medicine,
University of Missouri-Kansas City School of Medicine and Truman Medical Center

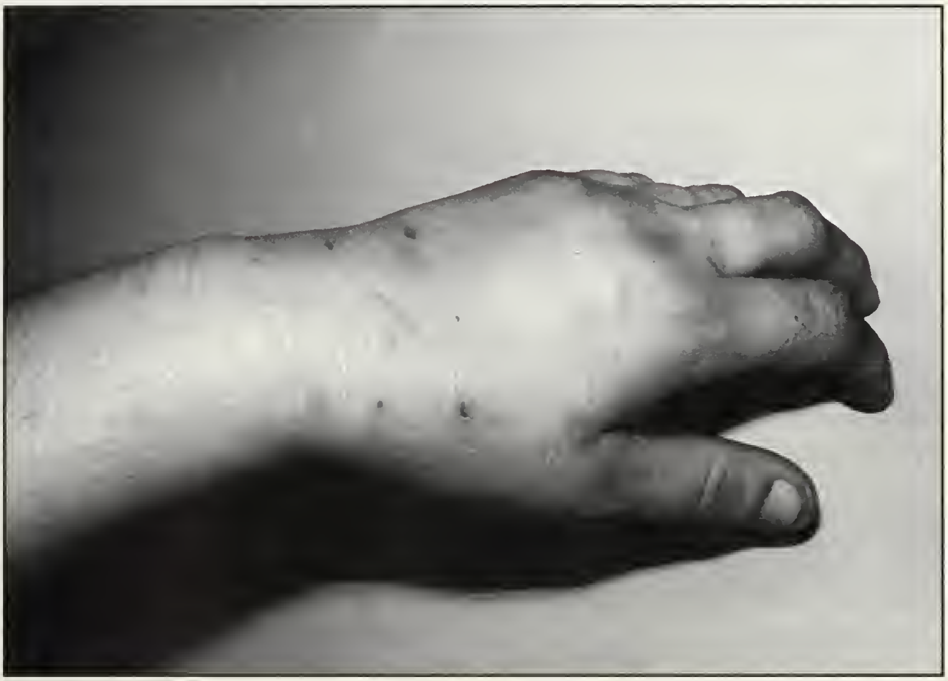

Figure 1

A 23-year-old male presents to the emergency department complaining of pain and swelling of the left wrist and hand. He states he was pulling on his neighbor's cat's tail yesterday when he was bitten by the cat. The patient has tenderness to palpatation in the area of redness (Figure 1). Range of motion of the wrist is slightly diminished. The patient has no known allergies.

1. What organism is most likely responsible for the patient's infection?

- **a. Pseudomonas aeruginosa**
- **b. Pasteurella multocida**
- **c. Staphyloccus aureus**
- **d. Eikenella corrodens**

2. What antibiotic would be the most appropriate for treating this infection?

- **a. Cephalexin**
- **b. Erythromycin**
- **c. Doxycycline**
- **d. Amoxicillin/clavulanic acid**

(See answer on next page.)

Specialty Quiz Answer

The Emergency Medicine Quiz question is located on the previous page.

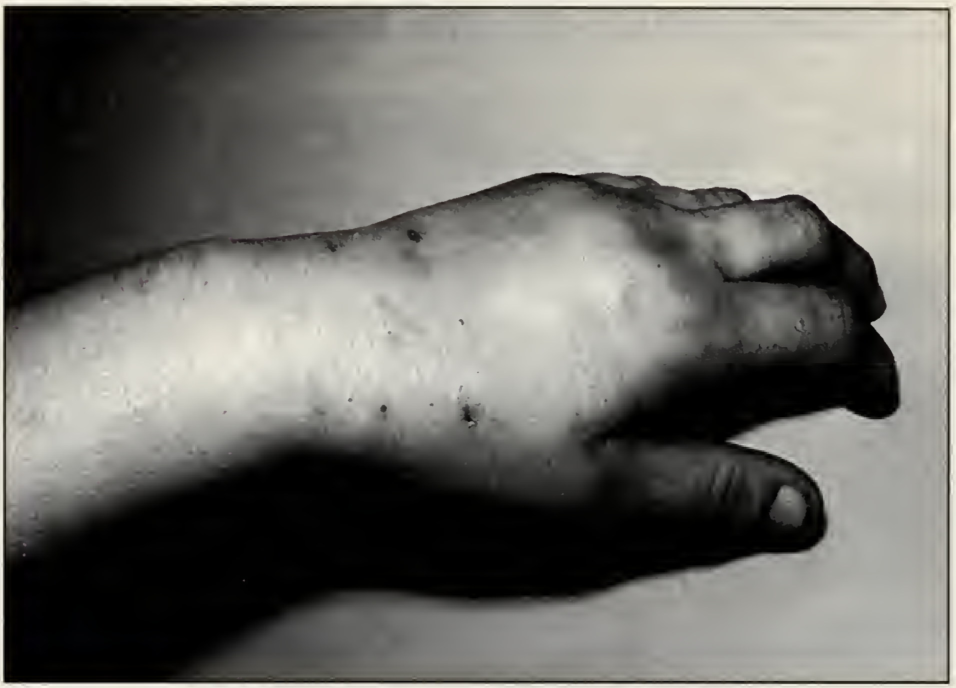

Figure 1 repeated

ANSWER: 1. b. Pasteurella multocida
2. d. Amoxicillin/clavulanic acid

Cat bites account for about 10% of reported animal bites in the United States. The majority of the wounds are located on the forearm and hand, and most of the bites result in puncture-type wounds due to the long slender fangs of cats.

Pasteurella multocida is the major pathogen found in wound infections due to cat bites. It is isolated from half to three-quarters of cultured cat-bite wound infections. Staph aureus can also be present. Cellulitis secondary to p. multocida develops quickly, usually within 24 hours of the bite. Serious bone and joint infections, as well as sepsis and meningitis, can be caused by p. multocida.

Treatment of cat-bite wounds includes tetanus immunization, wound cleansing, and copious irrigation. Adequate irrigation is generally not possible with puncture wounds so they should not be closed. Prophylactic antibiotics should be administered to high-risk patients (i.e. puncture-type, cat-bite wounds, particularly of the hands, and immunocompromised patients). The antibiotic choice should include coverage for both staph aureus and p. multocida. Amoxicillin/clavulanic acid or a combination of pencillin and a first generation cephalosporin are recommended for prophylaxis to cover both of these organisms. Pencillin is the drug of choice for known p. multocida infections. Penicillin allergic patients can be treated with doxycycline. P. multocida is relatively resistant to erythromycin and the first generation cephalosporins so these agents should not be used alone.

Rabies prophylaxis must also be considered. The decision to initiate prophylaxis is largely dependent on whether cat rabies is present in the geographical area where the bite occurred when the animal is not available for observation. MoMed

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The Use of Standard Management Reports In Medical Practice

Tom Bennett, MBA, MDiv, MSW, GCG
Terry J. Brennan, MBA, FACMPE, FHFMA
N. Rock Erekson, MBA, CMPE

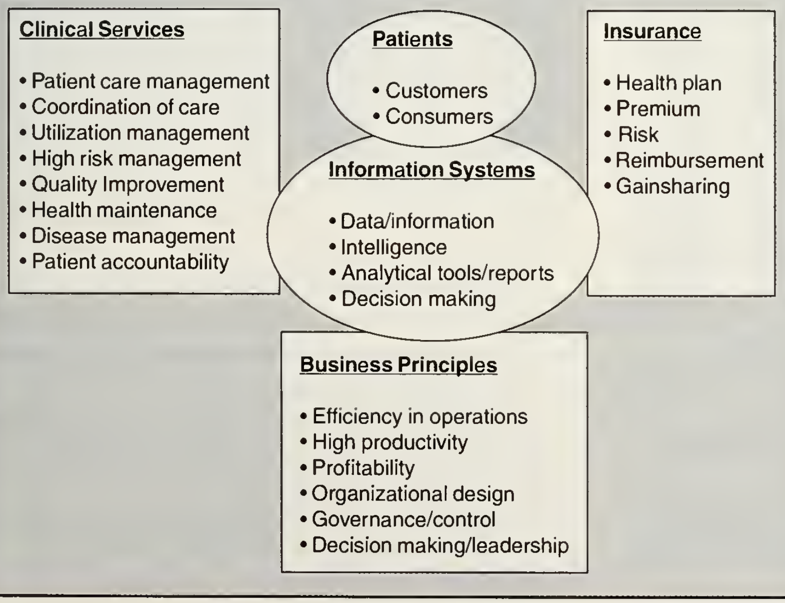
As physicians continue along the integration continuum, and as they develop group practice and physician directed healthcare systems, they are faced with balancing the three core components of healthcare delivery, namely, clinical management, insurance management, and business practice management (Diagram 1).[1]

Physicians are quickly realizing that they have to medically manage the care of their patients, use cost effective modalities that work, and disregard those that do not work. They must focus on improving health outcomes in the populations they serve, supplementing episodic care and production of services with an epidemiological perspective and disease prevention strategies.[2] At the same time they must grapple with taking more control over the premium, and actively participating in "gainsharing" arrangements with payors for good medical management and utilization of patient care.

Of these three core components described in Diagram 1, the component that has had the least attention is the area of business practice management. This has been due in part to the lack of experienced, high calibre medical practice managers. Historically, hospital systems and health plans have controlled the lion's share of experienced health care personnel, but this situation is now changing. Physicians, therefore, in order to become competitive must have access to experienced management and technical health care professionals. Currently, many accounting firms and physician practice management companies are actively working to fill this void. How effective they will be still remains to be seen.

Diagram 1

The Elements of Health Care Delivery


Clinical Services
• Patient care management
• Coordination of care
• Utilization management
• High risk management
• Quality Improvement
• Health maintenance
• Disease management
• Patient accountability
Patients
• Customers
• Consumers
Insurance
• Health plan
• Premium
• Risk
• Reimbursement
• Gainsharing
Information Systems
• Data/information
• Intelligence
• Analytical tools/reports
• Decision making
Business Principles
• Efficiency in operations
• High productivity
• Profitability
• Organizational design
• Governance/control
• Decision making/leadership

During a recent site visit to a multispecialty group practice, the physician leader stated that he and the rest of his colleagues were quite nervous and anxious because they were managing the practice "on the fly" due to the lack of concrete, current, and reliable information about the overall performance of the practice. He further stated that apart from the monthly income statements from the accountant,

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the physicians are completely in the dark concerning the health, productivity, profitability, and liability of the practice. He finally stated: " Entering into managed care contracts without prior knowledge is an absolute nightmare." The situation described above may be more common than we would like to imagine.

As the practice of medicine continues the transition from a "cottage industry" phase into a more tightly integrated group practice mode, a need has arisen for physicians to assimilate business and corporate principles, and to have access to healthcare management professionals in order to cope with the complexities and challenges of managing a large medical practice, while at the same time, take advantage of the multiple opportunities that currently exist in medical practice.

The cornerstone of good business practice is the use of standard management reports that track the key components of the business concerning production, cost, profitability, growth, market share, and customer satisfaction. These reports are used by management to make the necessary decisions about the business. The information generated by these reports can also be enhanced to develop models and analytical tools for budgeting, pricing, strategic planning, managed care contracting, and group development.

This paper has been written to assist physicians in designing a basic set of reports that can be used by the physician to judge the performance of their medical practice, and more importantly, make informed decisions that will positively impact their practice. This basic set of reports will allow the physician to:

1. Establish a method to know and understand what is going on with the business side of their practices;
2. Establish targets and goals;
3. Develop an informed method of decision making;
4. Improve the efficiency of the practice;
5. Develop models for managed care contracting, cost accounting, and budgeting.

Because of constraints of space this paper will be written in four parts which will appear in upcoming issues of *Missouri Medicine*. The first part will include:

- Monthly revenue report
- Lag time report
- Monthly activity/productivity report
- Report on payor mix by charges
- Report on payor mix by cash

In order to generate these reports, a practice will need a computerized billing system coupled with a spreadsheet program such as Excel or Lotus.

This paper has been graphically formatted to demonstrate the features and functions of the various reports.

For purposes of illustration, the context of these reports is a multispecialty primary care group practice: Dr. Jones (OB/GYN), Dr. Smith (Internist), and Dr. Evans (Peds). Similar reports can be easily developed to capture information of sigficance for other specialties.

Due to the constraints of space, the reports have been formatted to include only the data on Dr Jones. An attempt has been made to keep this data consistent throughout the whole sequence of reports. Please note: the data in the reports are used for illustration purposes only.

Report 1. Monthly Revenue Report

The purpose of this "quick reference" report is to inform the physicians about their charges and cash receipts on a monthly basis and year-to-date (YTD) basis as compared to a predetermined target/budget, and to determine if the physicians are meeting their targets.

If there is a significant variance from the target and/or a trend (three months variance) has been established, then more detailed analysis should be conducted to determine the cause.

Please note: this report does not have "line item posting" i.e. matching cash to charges, it simply compares charges sent for the month/YTD to cash that was collected that month/YTD.

Nota Bene: the budget/targets are generally based on historical activity that has been adjusted for known and anticipated changes.

In order to estimate the collection rate, a six-month moving average is used in order to create "smoothing" of the data.

Calculation for the collection rate: Assumption: that the average collection period is 60 days, e.g. in Report 1, most of the charges billed in January will be collected in March.

Sum of cash from March - August = \$263,000
Sum of charges from January - June = \$421,000
Collection rate : 263,000/421,000 = 62.47%

Please note that in Report 1 the spike in charges for January accounted for higher than budgeted cash for March. Likewise, there was dip in charges for June, which resulted in lower than expected cash for August. Therefore, by using a "smoothing" technique through a moving average it avoids a misreading of the data.

Report 1. Revenue Report
Dr. Jones Aug. 1997

Month	Charges	Cash	Coll Rate
Jan	85,000	42,000	
Feb	72,000	41,000	
Mar	68,000	55,000	
Apr	75,000	43,000	
May	71,000	45,000	
Jun	50,000	42,000	
Jul	75,000	49,000	
Aug	72,000	29,000	62.47%
Total YTD	568,000	346,000	
Budget YTD	576,000	328,000	
Bud Var YTD	-8,000	18,000	
Monthly Ave	71,000	57,667	
Monthly Bud	72,000	41,000	
Monthly Var	-1,000	16,667	
Prev Yr YTD	560,000	358,400	66.00%

Report 2. Lag Time

This report is used to spot check, through random sampling, the lag times between the date of service (DOS), the date of billing (DOB) and the date of payment (DOP). It is assumed that the practice has established a standard that all billings should be sent one day from the date of service. In this sample report, the lag time for payment is from the DOS to DOP. It should be carefully noted that certain billing systems are not able to differentiate between DOB and DOS. This confusion will skew the data in the accounts receivable aging report. In Report 2 for example, the patient R. Henderson had a 41 day lag time from DOS to DOB which may be reflected in the AR report as 62 days instead of the actual 103 days.

The methodolgy for structuring this report is to randomly select a physician's major CPT codes that are at least three months old, which allows for the probability of payment made on charges. This random selection should be a calender month's activity with every 10th patient being selected for review.

By randomly sampling on a quarterly basis or as needed, the highest revenue generating CPT codes, trends and excessive lag times may be captured which may warrant further analysis. This report may also be run to assess the quality of the work of the billers to determine if there are outliers and/or trends. For example in Report 2, there are two accounts that have lag times from DOS to DOB of 41 days and 13 days. If this report were continued with added patients and these lag times continued, then immediate analyis should be conducted to determine if this should be discussed with the biller or the individual physician.

Although random sampling has been suggested, some practices may wish to use this methodology for every charge to patients whose insurance plan has a timely filing deadline in order to ensure no revenue is lost due to lag in the submission of the claims.

Report 2. Lag Time
Dr. Jones Aug. 1997

Patient	CPT Code	DOS	DOB	Lag Billing	DOP	Lag Paymt	Carrier
Henderson,R.	59400	1/2/97	2/12/97	41	4/17/97	103	UHC
Rogers, R.	59510	1/5/97	1/7/97	2	3/1/97	55	BX
Hughes, S.	76805	1/2/97	1/3/97	1	2/28/97	56	GHP
Wright, M.	58260	1/7/97	1/20/97	13	4/12/97	95	UHC
Smith, J.	88155	1/8/97	1/10/97	2	2/27/97	51	MCare

Report 3. Productivity/Activity Report

This is also a quick reference report whose purpose is to inform the physician in the group about his/her productivity as measured by the frequencies

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Continued from page 579

of their activity as compared to a predetermined target. The target is generally based on historical activity. This report may be run by physician and or by group by month. It may also be run by other subtotals with a one page summary.

This report is a gross indicator of productivity per patient encounters which are elements that physicians can easily relate to, and if there is a wide variance of activity in the range of 10% under or over, this would warrant further analysis to determine the cause of the variance. It is is equally important to verify the reason why the activity is over target as it is under target.

Nota Bene: The tracking of new patients is an important indicator of future business and growth, and vice-versa.

Report 3. Activity/Productivity
Dr. Jones Aug. 1997

Encounter Type	Current Month	Monthly Target	YTD	YTD Target	YTD Variance
New off visit	15	12	135	96	39
Est off visit	240	220	1,850	1,760	90
Consults	35	30	264	240	24
Hosp visit	56	60	410	480	-70
IP Hosp Proc	20	22	168	176	-8
OP Hosp Proc	10	15	125	120	5
Surgi Ctr Proc	12	10	100	80	20
Off Proc	20	35	200	280	-80
Lab	42	50	360	400	-40
Imaging	38	40	336	320	16

Report 4. Payor Mix Analysis By Charges

This report is an important indicator of the mix or type of patients by charges based on the primary payor serviced by the physician/practice. It is also a gross indicator of revenue production.

In this report 21% of Dr Jones' charges YTD are government patients i.e. 9% Medicare and 12% Medicaid. If this mix were to change to 50% government patients (25% Medicare and 25% Medicaid) it would a have a serious negative impact on cash receipts and cash flow, given the approximate reimbursement rate of 33% of usual and customary rates (UCR) for Medicaid and 45% for Medicare.

Report 4. Payor Mix by Charges
Dr. Jones Aug 1997

Payor	Charges YTD	Chgs YTD Percent	Charges Bud YTD	Percent
Medicare	51,120	9%	51,840	9%
Medicaid	68,160	12%	69,120	12%
PPO	255,600	45%	218,880	38%
HMO	56,800	10%	86,400	15%
Indemnity	56,800	10%	46,080	8%
Work Comp	28,400	5%	34,560	6%
Private	28,400	5%	23,040	4%
Self-pay	22,720	4%	46,080	8%
Total	568,000	100%	576,000	100%

Report 5. Payor Mix Analysis by Cash

This report is run to indicate the mix of patients by CASH receipts received by the physician. It is important to compare the percentage of charges to cash received by payor category. Please refer to the example above for comparison of charges to cash receipts by payor category.

Report 5. Payor Mix by Cash
Dr. Jones Aug. 1997

Payor Category	Cash		Cash	
	YTD	Percent	Bud YTD	Percent
Medicare	23,515	7%	25,000	8%
Medicaid	27,680	8%	22,960	7%
PPO	176,460	51%	157,440	48%
HMO	20,760	6%	26,240	8%
Indemnity	45,120	13%	49,520	15%
Work Comp	21,300	6%	20,600	6%
Private	10,405	3%	6,560	2%
Self-pay	20,760	6%	19,680	6%
Total	346,000	100%	328,000	100%

Conclusion

Shoshana Subhoff argues that the purpose of modern information technology should be used not only to automate and integrate activities, but to "informate" them- i.e. to generate streams of information/reports for intelligent decision making.[3] It is imperative, therefore, for physicians/practices to establish reporting systems that will help them be better informed and thereby more capable of making decisions that will enhance and improve their practices

The sample reports described are not written in granite, and should be enhanced and modified to meet the particular needs of the practice. If the practice does not have the staff to format these reports, there are technical resources available that can assist physicians/practices in this regard. As stated on page 576, other management reports will be featured in upcoming issues of *Missouri Medicine.* The topics include: CPT code analysis, AR aging, budget variance, demographic and utiliation reports. MoMed

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MSMS is preparing a handbook on the topic of management reporting. It will describe the reports in this article and other reports in more detail. This handbook will be made available to members upon request.

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Real Estate and the Medical User

Doug Kelly, RRT, MBA
David Cochran, SEC, CCIM

We are all aware that the delivery system in the health care industry is changing at mega speed. It is an accepted truism that cost will be an overwhelming determinate in the financial viability of a medical/surgical practice. Costs must be scrutinized as never before to give the physician an even chance at becoming a low cost, quality provider of their specialty. How to cope with change and the demand for lower cost without compromising quality is the issue of the day.

One such cost, which viewed in the big picture, is a major contributor and/or detraction to the financial performance of the physician's professional corporation, but receives little popular press, is that of real estate. Real estate is the point of delivery of the medical service. Its location, size, exterior appointments, interior finish, and contents are somewhat forgotten in the formula for the financial success of the medical practice. The cost of this necessary ingredient will affect the overall financial performance of the medical practice for years to come.

In past years most medical providers stayed near a major hospital if not in the hospital. With the decentralization of the medical delivery system, the consumer is becoming more demanding. Medical practices are now found in shopping malls, residential areas, in central business districts and other locations convenient to the consumer. The size of most practices has decreased with the need to control practice expenses. And the exterior as well as interior finishes have seen major changes in the past few years. Even furnishings have become more frugal with these changing times.

How to cope with change and the demand for lower cost without compromising quality is the issue of the day.

Should the professional corporation be looking to move, add physicians or downsize, space becomes a major concern as the cost of that space will directly affect the disposable income of the physicians. Therefore, it is imperative that a course of diligent planning be utilized in selecting location of the space, size of space, quality of finish, and the accompanying furniture and fixtures. Attention to detail will have a major impact on the future financial success of the medical practice.

The planning process begins with a market analysis of existing medical providers (competition), hospitals, ancillary services, providers of specialty services such as ambulatory surgery centers, consumer service centers, and existing access to all potential locations. It is important to consider other medical services or consumer convenience services as a potential synergistic catalyst to enhance the future performance of the professional corporation. Location of a medical practice will be as important as locating any other business dependent upon consumer acceptance.

Once the site has been selected, the space planning process can begin by considering the location of the building, parking, consumer access, physician access, and the amount of space per physician. It is important to also consider the need for ancillary services, their location to the facility or in the facility.

Upon completion of the space planning, the user of the space can now determine how to finish the exterior and interior of the facility. The exterior should be in keeping with the environment and surrounding properties, however, the interior should consider function over aesthetics. A combination of the two will result in the maximum utilization of the dollars spent. Therefore, advanced planning is very important to quantify the cost of the real estate in question.

Once the planning process is complete and the cost determined, the financing process must be pursued prior to commencement of the project. There are two popular methods of financing in today's market. The owners of the professional corporation can seek a traditional form of financing which may be both construction financing and permanent financing or they may seek financing in the form of a lease. There are two forms of lease financing found in the current market, capital leases and operating leases.

A capital lease may be defined as a financing vehicle with a traditional structure shown on the balance sheet as a long term liability while an operating lease is considered to be an operating expense much the same as traditional operating expenses whether fixed or variable. Some of the benefits of an operating lease for the professional corporation, which chooses this form of financing, are as follows:

1. Enhanced financial ratios

The real estate asset, mortgage debt, lessor's equity position in the facility does not appear on the professional corporation's balance sheet. Lease payments by definition are an operating expense of the professional corporation. Consequently, the financial ratios such as return on equity, return on assets, and interest coverage improve compared to an "on balance sheet" (traditional bank financing) approach.

2. Retention of tax benefits

Because the transaction places the significant benefits and burdens of ownership with the professional corporation, the professional corporation has the ability to deduct all lease payments as an operating expense. There are certain lease structures which will treat the leases as the owner of the real estate allowing for the deduction of depreciation. However, this will require proper counsel and planning during the financing process.

3. Financing flexibility

With a proper lease structure, the user will retain maximum capital, lower the cost of financing which results in greater control and flexibility in the use of the professional corporations financial assets.

4. Realization of future appreciation

Through proper structuring of the lease document, the medical user can provide for a fixed-rate purchase option (FPO), thereby having the ability to realize future appreciation on the facility.

As is evident when contemplating a new facility or a renovation of your existing facility there is much to consider. Practice costs continue to rise while at the same time there exist compression on fees the physician will be reimbursed. All costs must be scrutinized as never before to give the physician an even chance at becoming a competitive provider of medical services. In dealing with real estate, the planning process will determine the financial viability of the practice well into the future. Real estate can be a major asset or a major liability. In our next article we will explore the potential of "off balance sheet" financing and the benefits associated therein. MoMed

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Assessment and Diagnosis of Adult Attention Deficit/Hyperactivity Disorder

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Attention-Deficit Hyperactivity Disorder (ADHD) is characterized by an ongoing pattern of inattention and/or hyperactivity beginning in early childhood and resulting in clinically significant impairment in functioning. Because ADHD has been considered a behavioral disorder of childhood, it has been long assumed that the severity of ADHD symptoms decrease and eventually disappear as the child reaches adulthood. More recently, however, ADHD has come to be broadly recognized as a disorder of adulthood as well as childhood. This recognition stems in part from research indicating that more than 50% of those diagnosed with the disorder in childhood continue to manifest significant attention-related difficulties into late adolescence and adulthood.[1, 2, 3] Furthermore, some of those diagnosed with ADHD as children have been found to continue to meet full criteria for the syndrome as adults.[2] There is no clear empirical evidence as to the prevalence of this disorder in adults; estimates range from 0.3% to 6% of the entire adult population.[4, 5]

Though ADHD in adulthood has only recently begun to receive extensive attention from researchers, there is empirical evidence that the symptoms of ADHD have serious consequences for adult functioning. Long-term follow-up studies of children diagnosed with ADHD have indicated that as adults these individuals were significantly more likely to abuse recreational drugs, engage in antisocial behavior, and be diagnosed with antisocial personality disorder than were comparison subjects.[2, 6] Additionally, follow-up studies consistently have found lower educational and vocational achievement in adults diagnosed as hyperactive in childhood.[2, 6]

Concurrent with the growing interest in adult ADHD exists controversy over the application of such a diagnosis. Some suggest that applying existing criteria for ADHD to adults is problematic. The primary concern appears to be that these criteria are based on studies of children with the disorder and, when applied to adults, may result in significantly impaired individuals not receiving the diagnosis of ADHD and thus recognition of the severity of their symptoms.[7] On the other hand, both professionals[4] and those in the lay press[8] have suggested that a diagnosis of adult ADHD (especially when self-diagnosed) may be used as a convenient but potentially inaccurate biological explanation for life difficulties, such as job loss or relationship dissatisfaction. Amid this controversy, clinicians are left unclear as to how to approach the diagnosis and treatment of ADHD among their own adult patients.

This article will provide a broad overview of issues relevant to working with adult patients who may be suffering from ADHD. The information provided herein is intended to increase the clinician's ability to appropriately assess for and diagnose ADHD in their adult patients. Guidance is also provided regarding treatment issues.

Diagnostic Criteria

There are two primary diagnostic systems currently in use for determining the presence or absence of adult ADHD. The first system is presented in the Diagnostic and Statistical Manual-IV (DSM-IV) of the American Psychiatric Association. [9] The DSM-IV characterizes ADHD as an ongoing pattern of inattention and/or hyperactivity that is developmentally inappropriate. Onset of symptoms must occur prior to age seven years. Additionally, impairment related to the symptoms must occur in more than one setting and clinically significant impairment should be evident in at least one area of functioning. [9] These criteria and the specific number of symptoms necessary to receive a diagnosis of ADHD (see Table 1) apply to both children and adults, though the DSM-IV does describe the differential expression of some symptoms in adults as opposed to children. For example, children may display inattention to details in schoolwork, whereas adults may be inattentive to details of job-related tasks.

Though the added description of adult expression of relevant symptoms increases the clinician's ability to utilize DSM-IV criteria, the diagnostic criteria are nonetheless based on research with children. Preliminary evidence from research with a community sample of adults suggests that using DSM-IV criteria to diagnose adult ADHD may result in only those with very extreme ADHD-related behaviors being diagnosed with the disorder.[7] It is important to note, however, that there is no evidence indicating that using less stringent criteria for diagnosis would accurately identify those experiencing clinically significant impairment due to their inattention and hyperactive symptoms.[4]

Paul Wender, a psychiatrist at the University of Utah who is widely noted for his research on adult ADHD, has proposed a somewhat different set of criteria

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Table 1
DSM-IV Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder [9]

A. Either (1) or (2):
  1) six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

  Inattention
  - a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
  - b) often has difficulty sustaining attention in tasks or play activities
  - c) often does not seem to listen when spoken to directly
  - d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
  - e) often has difficulty organizing tasks and activities
  - f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
  - g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
  - h) is often easily distracted by extraneous stimuli
  - i) is often forgetful in daily activities

  2) six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

  Hyperactivity
  - a) often fidgets with hands or feet or squirms in seat
  - b) often leaves seat in classroom or in other situations in which remaining seated is expected
  - c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
  - d) often has difficulty playing or engaging in leisure activities quietly
  - e) is often "on the go" or often acts as if "driven by a motor"
  - f) often talks excessively

  Impulsivity
  - g) often blurts out answers before questions have been completed
  - h) often has difficulty awaiting turn
  - i) often interrupts or intrudes on other (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattention symptoms that caused impairment were present before age 7 years.
C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).
D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
E. The symptoms do not occur exclusively during the course of Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

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for adult ADHD, referred to as the Utah Criteria[5, 10] (see Table 2 for a summary; see Wender, 1995, pp. 122-134 for a complete description) . Like the DSM-IV, the Utah Criteria requires that the presence of ADHD in childhood be established. A determination of a childhood history of ADHD can be based on either DSM-IV criteria or on Wender's criteria that require the presence of hyperactivity and attention deficits, as well as one of the following: school behavior problems, impulsivity, overexcitability, and temper outbursts.[5, 10] Current adult symptoms must include both motor hyperactivity and attention deficits as well as the presence of two of five other behaviors (e.g., emotional overreactivity). ADHD is ruled out when symptoms of bipolar and depressive mood disorders, schizophrenic spectrum disorders, or borderline personality disorder are present. Additionally, if criteria are met for antisocial personality disorder or alcohol/drug abuse within the past year, then a diagnosis of ADHD is not made.

The primary advantage of the Utah Criteria is their clear developmental relevance. However, it is important to note that the Utah Criteria were developed for research purposes and as such were intended to identify a homogeneous group.[5] The Utah Criteria does not provide a diagnosis of adult ADHD in which the symptoms relate primarily to inattention without clear evidence of hyperactivity. Thus, practitioners must rely solely on the DSM-IV to diagnose individuals presenting only with attention difficulties. Furthermore, the criterion that ADHD is ruled out in individuals with antisocial personality disorder or evidence of recent alcohol/drug abuse should not be followed in clinical practice because research has indicated that these difficulties are fairly common among adults with ADHD.[11]

In summary, without clear empirical evidence to indicate the most appropriate diagnostic criteria for ADHD in adults, there will continue to be some confusion regarding how best to make a diagnosis. However, there is clearly a consensus that the ADHD symptoms must have begun in early childhood. In adulthood, there must be pervasive and cross-situational hyperactivity-impulsivity and/or inattention. Furthermore, these symptoms must be the source of clinically significant impairment. Additionally, antisocial personality disorder and substance abuse disorders should not be used as a basis for ruling out ADHD, but rather should be considered as possible additional diagnoses. The presence of a schizophrenic spectrum disorder should rule out a diagnosis of adult ADHD, whereas when a mood disorder or borderline personality disorder is present, a diagnosis of ADHD should be made with caution.

Table 2
Summary of the Utah Criteria for Adult ADHD [10]

A. A history of childhood behavior consistent with ADHD.

B. **Motor hyperactivity** indicated by such difficulties as an inability to relax or continuously engage in activities requiring little movement; restlessness.

C. **Attention deficits** indicated by difficulty staying focused on a single task or conversation; easily distractable.

D. Two of the following:

1. **Affective lability** indicated by clear mood shifts from depressed to normal to excited; with mood shifts usually lasting hours and occasionally days.
2. **Hot temper** indicated by explosive outbursts that are followed by quickly calming down.
3. **Emotional overreactivity** indicated by excessive reactions to ordinary stressors.
4. **Disorganization and inability to complete tasks** indicated by lack of organization in tasks related to job, home, or school.
5. **Impulsivity** indicated by making decisions very quickly and without thinking through the implications; difficulty delaying taking action.

Assessment

Assessment of ADHD in adults is a complex matter. The clinician must gather information regarding current symptoms as well as those occurring a decade or more ago. Additionally, all patients who meet full criteria for ADHD as adults, by definition, have had an impairing behavior disorder for the vast majority of their lives. Thus, a complete assessment must include consideration of the impact that the primary symptoms have had on the patient's ability to maintain relationships and succeed in the realms of school and work.

In order to thoroughly assess for adult ADHD, information about the patient's behaviors should be gathered from both the patient and from significant others in the patient's life. Information regarding symptoms is best gathered through semi-structured interviews and behavior checklists.

Informants. The most unique aspect of assessing for adult ADHD is the necessity of establishing that the disorder was present before the individual was seven years old. Ideally, someone who knew the patient as a child, most likely a parent, would be available to provide details about the patient's childhood behavior. Medical or school records are also a potential source for such information.

In addition to patient report, requesting that a spouse, parent, or significant other describe the patient's current behaviors should be standard practice in the assessment of ADHD in adults.[5, 12] The person who currently spends the most time with the patient is generally the best informant. Based on findings from both research[13] and clinical practice,[5,12] there are often discrepancies between patient and informant reports of relevant symptoms. Wender suggests that this is due to difficulties that adults with significant attention or hyperactivity problems may have in comparing their own behaviors to that of other adults, or may be due to having spent a lifetime minimizing the degree of their maladaptive behavior.[5] Thus, in some cases, the significant other's report may provide a clearer picture of relevant symptomatology and increase the clinician's ability to make a diagnosis. Additionally, use of multiple informants reduces the risk that an individual may exaggerate his or her difficulties in hopes of receiving the diagnosis and/or stimulant medication.

Assessment Tools

Behavior Checklists. Behavior checklists are useful for assessing both current and past behaviors as reported by the patient and other informants. The advantage of behavior checklists is that they can be completed quickly and easily. Additionally, informants who are unable to attend the patient's assessment can still provide a report of the patient's childhood and/or adult behaviors. This is particularly important in attempts to gather information about past behavior from parents who may not currently live near the patient.

The Wender Utah Rating Scale is a 61-item scale designed to aid in gathering information about childhood behavior problems relevant to ADHD.[13] This scale can be filled out by both the patient and someone familiar with the patient as a child (e.g., a parent). Validation research with this scale has indicated 25 items that were most useful in differentiating adults with ADHD from other adults.[13]

Kane and his colleagues developed a behavior checklist that is used in their clinic at the University of Massachusetts Medical Center to assess current behavior difficulties in individuals potentially suffering from ADHD.[12] The checklist consists of 18 symptoms associated with ADHD in adults. The respondent is asked to rate how problematic each symptom is for the patient. This type of checklist should be filled out by both the patient and the significant other most familiar with his or her current behavior (e.g., a spouse).

Patient Interviews. The wealth of information necessary to make a diagnosis and adequately conceptualize related difficulties ideally should be gathered from the patient via a semi-structured interview. This method of assessment provides clear guidance for the type and amount of information to gather. Kane and his colleagues present a very thorough semi-structured interview for adult ADHD in an appendix to their book chapter.[12] Additionally, Wender's more narrowly focused Targeted Attention-Deficit Disorder Symptoms Rating Scale consists of interview questions and clinician's observations regarding current behaviors and potential impairment in important roles (e.g., work).[5] If a semi-structured interview is not feasible, the clinician should query the patient about current and past ADHD symptoms, as well as symptoms that suggest the presence of a disorder other than ADHD or other mental health problems likely to be comorbid with ADHD (e.g., substance abuse). Furthermore, if the presence of ADHD is likely, the clinician should inquire about the patient's academic and work histories, as well as about interpersonal relationships.

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Table 3
Procedure for the Assessment and Diagnosis of ADHD in Adults

The following presents a step-by-step guide to a complete assessment for a patient presenting with ADHD symptoms. Findings based on the information gathered in any one step that are consistent with a diagnosis of ADHD should prompt the clinician to proceed to the next step.

1. a) Patient and spouse/significant other complete a behavioral checklist regarding current behaviors, such as the Adult ADHD checklist used at the Massachusetts Medical Center.
   b) Patient completes Wender Utah Rating Scale to gather information on childhood behaviors.
   Note: The checklists can be sent to the patient prior to the first appointment or can be filled out in the practitioner's office.

2. A semi-structured interview, such as the ones presented by Wender[5] or by Kane[12] and his colleagues, should be completed with the patient and with the patient's spouse/ significant other.
   Note: A single interview can be conducted with both the patient and the spouse/ significant other if the clinician believes that neither individual's answers will be affected by the other's presence.

3. a) Send patient's parents a copy of the Wender Utah Rating Scale to gather parent's perceptions of patient's childhood behavior. If possible, discuss parents' impressions directly with them.
   b) Collect school and medical records to examine for evidence of ADHD symptoms in early childhood.

4. a) Use information gathered from the patient, his or her parents, and his or her school records to ascertain the presence of ADHD in childhood.
   b) Use information gathered from the patient and his or her spouse/significant other to determine whether the patient meets either current DSM-IV criteria or the Utah Criteria.
   Note: Individuals often find it difficult to report on their own behaviors. Given discrepancies between the patient report and that of an apparently reliable other, the physician may find it appropriate to give more credence to the report of the significant other when determining the presence or absence of an individual symptom.

5. If both childhood and adult criteria are met, a diagnosis of ADHD is appropriate.

Treatment

ADHD in adults is treated primarily with stimulant medication. A series of studies by Wender and his colleagues has indicated that 50% to 60% of adults with ADHD experience a clinically and statistically significant improvement when receiving methylphenidate or pemoline.[14, 15, 16] These findings indicate a somewhat lower response rate for adults as compared to children. However, in a recent study, subjects were given a stronger dose of methylphenidate as compared to the dose given in previous research.[17] Findings indicated a 78% response rate during treatment with stimulant medication as compared to a 4% response rate with placebo. Antidepressants, such as buproprion or imipramine, are used to treat adult ADHD in cases in which stimulant medication does not appear to be having an effect or stimulants are otherwise inappropriate.

The following recommendations are based primarily on several specific suggestions made by Wender for treating adult ADHD with stimulant medications.[5] Initially, the patient should be started on a low dose of the stimulant medication. The dose should be increased until there is no additional improvement in symptoms or the side effects become too aversive. Side effects of stimulant medications may include agitation, insomnia, dry mouth, decreased appetite, hypertension, sedation, or fogginess. Both the amount of each dose and the timing of the doses throughout the day must be established for each individual patient. Once these details have been determined, a structured dosage schedule should be implemented. Many adult patients with ADHD find it necessary to implement a reminder system to help them consistently take their medication as scheduled. Use of a multi-alarm watch set to "go off" when it is time for the next dose may be helpful in this regard.

Improvements in the patient's symptoms should be assessed via information provided by both the patient and a significant other in the patient's life. As noted previously, some adults with ADHD are particularly poor informants regarding their symptoms and thus may not be as aware of changes in their behavior as are those who live with the patient.[5] Readministering checklists or rating scales and comparing the responses to those made during the initial assessment provide the clinician with a systematic means by which to examine symptom change once pharmacological treatment is initiated.

Patients with adult ADHD who are also at high risk for substance abuse present a particular treatment challenge. This is noteworthy because many of those who have ADHD as adults also have a comorbid substance abuse diagnosis.[11] Due to the increased risk in this population, all adult patients given a diagnosis of ADHD should be assessed for drug abuse by interview and a urine test. Patients found to be currently abusing substances, or those who are at high risk for future substance abuse, should not be treated with stimulant medications because of the potential for abusing these medications.[5] Kane and his colleagues suggest that such patients be referred for treatment of substance abuse problems, and that treatment for symptoms of ADHD only be implemented in those cases in which successful treatment of the substance abuse problem does not result in a significant reduction in ADHD-related difficulties.[12] Relatedly, Kane and his colleagues also indicate that all patients should be asked to abstain from even moderate use of alcohol and marijuana before and during treatment.[12] They note that in their clinical experience some patients will find that their symptoms remit without further treatment once they begin to abstain from even moderate substance use.

Adults with ADHD may also benefit from psychological therapies provided by a psychologist or other type of therapist who is familiar with ADHD in adulthood. Therapy focusing on problems related to core symptoms of ADHD, such as time management, self-organization skills, self-control, and anger management could be beneficial.[12] The consequences of suffering from ADHD for an extended period of time, including low self-esteem, interpersonal difficulties, and lack of vocational achievement, may also need to be treated.[5] Interpersonal difficulties may be improved through marital or family counseling, as well as through skills training in problem-solving, communication, and conflict negotiation.[12] Vocational difficulties may be addressed by referring the patient to a career counselor.[18]

Conclusion

Thorough assessment techniques are necessary to correctly diagnose and treat adults with ADHD. A failure to consider a diagnosis of ADHD in adults presenting with significant attention problems or hyperactivity may result in a patient not receiving available treatments, whereas a rush to diagnose without performing an adequate assessment may result in inappropriate use of stimulants or other medications.

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John P. Atkinson, MD, received a $1,199,110 five-year grant from the National Institute of Allergy and Infectious Diseases for a research project titled “Complement Receptor One (CR1): Structure and Function.” Dr. Atkinson is a professor of medicine and molecular microbiology at Washington University School of Medicine.

Robert W. Thompson, MD, received a $76,949 one-year grant from the National Institute on Aging for a research project titled “Smooth Muscle Cell Senescence in Aortic Aneuryms.” Dr. Thompson is an assistant professor of surgery at Washington University School of Medicine.

John G. Neely, MD, received a $1,175,040 five-year grant from the National Institute on Deafness and Other Communication Disorders for a project titled “Development of Clinician Researchers in Academic ENT.” Dr. Neely is a professor of otolaryngology at Washington University School of Medicine.

The Missouri Society of Otolaryngology - Head and Neck Surgery recently installed **Richard Martin, MD**, Cape Girardeau, as President; **Robert Kletzker, MD**, St. Louis, as President-Elect; **Greg Renner, MD**, Columbia, as Secretary-Treasurer; and **Edgar I. Ailor, III, MD**, Columbia, as Alternate to the Board of Governors. **Dr. Kletzker** was also elected to the Board of Governors.

Nathanial Murdock, MD, has been elected president of the National Medical Association (NMA), the largest group of minority physicians in the United States. Dr. Murdock is a clinical assistant professor of obstetrics and gynecology at Washington University School of Medicine.

Richard Bradley, MD, was chosen as the new chairman of the Physician Insurers Association of America (PIAA). Dr. Bradley, a general surgeon, is President and CEO of Missouri Medical Insurance Company (MOMEDICO).

The Missouri Academy of Family Physicians recently installed its 1997-98 officers. **Mike Munger, MD**, Kansas City, was installed as Vice President and **David Auner, MD**, Ironton, as Secretary-Treasurer. Directors installed included **Craig Holzem, MD**, Washington; **Thomas “Larry” Huffman, MD**, Branson; **James McDowell, MD**, Mexico; and **Scott Wood Thompson, MD**, Kansas City. **Mark Martin, MD**, Lee’s Summit, stepped up to Chairman of the Board of Directors of the statewide group of family physicians. The officers were installed by **Patrick B. Harr, MD**, Maryville, who is President of the American Academy of Family Physicians.

Martin B. Wax, MD, received a $25,000 one-year grant from the American Health Assistance Foundation for a research project titled “Autoimmunity and Normal Pressure Glaucoma.” Dr. Wax is an associate professor of ophthalmology and visual sciences at Washington University School of Medicine.

Marc R. Hammerman, MD, received a $3,780,734 five-year grant from the National Institute of Diabetes and Digestive and Kidney Diseases for a research project titled “Renal Genes, Growth Factors, Development and Disease.” Dr. Hammerman is the Chromalloy Professor of Renal Diseases in Medicine and an associate professor of cell biology and physiology at Washington University School of Medicine.

Ralph G. Dacey, Jr., MD, professor and head of nuerological surgery at Washington University School of Medicine in St. Louis, has been named the Henry G. and Edith R. Schwartz Professor of Neurological Surgery.

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In Memoriam

Irwin B. Horitz, MD, 92, St. Louis, died May 14, 1997. Dr. Horwitz, an orthopaedic surgeon, was founder of the old Faith Hospital in St. Louis and a clinical professor for many years at Washington University School of Medicine and St. Louis University School of Medicine. He was a member of the Missouri State Medical Association.

Clarence John Shockley, MD, 74, Lee's Summit, died May 23, 1997. Dr. Shockley, an obstetrician/gynecologist, was a member of the Missouri State Medical Association.

Raymond Ritter, Sr., MD, 92, Cape Girardeau, died May 30, 1997. He received his medical degree from St. Louis University School of Medicine in 1932 and in 1933 he moved to Cape Girardeau and established a medical practice that has since grown into Orthopaedics Associates of Southeast Missouri. Dr. Ritter was a member of the Missouri State Medical Association and served as a vice president.

Wilburn C. Missey, Jr., MD, 81, Creve Coeur, died June 5, 1997. Dr. Missey earned his medical degree from St. Louis University in 1942. He was appointed to the staff of St. John's Mercy Hospital and the faculty of St. Louis University Medical Center in 1947, and practiced internal medicine in St. Louis and later at St. John's. Dr. Missey was a member of the Missouri State Medical Association.

E.T. Irinyi, DO, 78, Gower, died June 24, 1997. Dr. Irinyi received his degree in osteopathic medicine from Still Medical College in Des Moines, IA. After 50 years as a general practitioner, he retired in 1994. Dr. Irinyi was a member of the Missouri State Medical Association.

James J. Hasenmueller, MD, 66, Sunset Hills, died July 5, 1997. Dr. Hasenmueller received his medical degree at St. Louis University School of Medicine. He was a member of the Missouri State Medical Association, American Board of Surgery, and a mentor at St. Anthony's Medical

Joseph G. Kelly, MD, 52, Liberty, died July 5, 1997. Dr. Kelly received his medical degree from the University of Missouri-Columbia School of Medicine in 1971. He served in general practice the Raytown Clinic for two years before joining North Kansas City Hospital, where he served as an anesthesiologist. He was a member of the Missouri State Medical Association, American Medical Association, American and Missouri Society of Anesthesiologists, Clay-Platte Medical Society.

August J. "Gus" Furla, MD, 82, St. Louis, died July 6, 1997. Dr. Furla received his medical degree from St. Louis University School of Medicine and was in private practice in St. Louis for more than 40 years. He was a member of the Missouri State Medical Association, American Medical Association, St. Louis Metropolitan Medical Society.

Grover Patterson, MD, 75, Carthage, died July 23, 1997. Dr. Patterson received his medical degree from Duke University Medical School. He established his family practice in Carthage in 1952 and retired in 1987. He was a past president of the Jasper County Medical Society and a former state vice president of the Academy of Family Physicians. Dr. Patterson was a member of the Missouri State Medical Association.

Raymond O. Keltner, MD, 77, Peculiar, died July 26, 1997. He received his medical degree from Kansas State University. He practiced for 43 years in Raytown and the metropolitan Kansas City area. Dr. Keltner was a member of the Missouri State Medical Association.

Owen S. Kantor, MD, 54, St. Louis, died July 27, 1997. Dr. Kantor received his medical degree from the University of Missouri-Columbia School of Medicine. He was in private rheumatology practice in St. Louis for 23 years and served as an associate professor of medicine at Washington University. Dr. Kantor was a member of the Missouri State Medical Association.

Donald E. Wells, MD, 66, Jacksonville, Fla., died in July 1997. Dr. Wells, a nephrologist, was a member of the Missouri State Medical Association.

New Members

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Univ of KY-Lexington 1982

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St. Louis, MO 63146
St. Louis Univ 1992

Brian Walton, MD IM
3259 January Ave., #3
St. Louis, MO 63139
Univ of KS-Kansas City 1997

CME Listing

September

4 thru 6 - *St. Louis*: 4th Annual Current Topics in Cardiothoracic Anesthesia. Perioperative Management. 20 credit hours. Call Washington University School of Medicine 314-362-6891.

10 thru 13 - *St. Louis*: Spinal Fracture Fixation. Call St. Louis University School of Medicine 314-577-8167.

12 - *St. Louis*: Multi-Modality Approach to Cancer. Call St. Louis University School of Medicine 314-577-8167.

12 - *St. Louis*: Eighth Annual Ultrasound Conference. Call St. John's Mercy Medical Center 314-569-6290.

14 & 15 - *St. Louis*: Spine. Call St. Louis University School of Medicine. 314-577-8167.

17 - *St. Louis*: Tenth Annual Trauma Care Conference. Call St. John's Mercy Medical Center 314-569-6290.

18 thru 20 - *St. Louis*: Contemporary Cardiothoracic Surgery. Call Washington University School of Medicine 314-362-6891.

19 - *St. Louis*: Endoscopic Surgery: Carpal Tunnel. Call St. Louis University School of Medicine 314-577-8167.

22 thru 25 - *St. Louis*: Pterional Approaches. Call St. Louis University School of Medicine 314-577-8167.

24 thru 26 - *Jefferson City*: Essentials of Infection Control - 7th Annual Conference. 16 credit hours. Call Missouri Department of Health 573-751-6115.

26 - *St. Louis*: Founders Day Program. Call St. Louis University School of Medicine 314-577-8167.

October

2 thru 5 - *St. Louis*: Surgical Management of Skull Base. Call St. Louis University School of Medicine 314-577-8167.

4 - *St. Louis*: Menopause and Beyond. Call St. Louis University School of Medicine 314-577-8167.

6 & 7 - *St. Louis*: Fundamental Critical Care Support. Call St. Louis University School of Medicine 314-577-8167.

6 thru 10 - *St. Louis*: Medicolegal Death Investigator. Call St. Louis University School of Medicine 314-577-8167.

10 thru 12 - *St. Louis*: Neuroanatomy for Neuro/Psych. Call St. Louis University School of Medicine 314-577-8167.

17 thru 19 - *St. Louis*: Practical Issues in Leading-edge Radiology II. 25.5 credit hours. Call Linda Macker 314-362-2916.

17 thru 19 - *St. Louis*: Surgical Treatment Mastoid Cavities. Call St. Louis University School of Medicine 314-577-8167.

18 - *St. Louis*: New Techniques in Urinary Incontinence and Female Urology. 8.5 credit hours. Call Washington University School of Medicine 314-362-6891.

23 thru 25 - *Overland Park, KS*: 75th Annual Fall Clinical Conference. Call Linda Smutz, Kansas City Southwest Clinical Society 816-523-3383.

24 thru 26 - *St. Louis*: Peripheral Nerves. Call St. Louis University School of Medicine 314-577-8167.

31 - *Kansas City*: Laboratory Diagnosis of Thrombotic & Hemostatic Disorders. 5.5 credit hours. Call Kim McChesney 816-932-5140.

31 thru Nov. 1 - *St. Louis*: Sellar & Parasellar Pituitary Tumors. Call St. Louis University School of Medicine 314-577-8167.

25 - *Joplin*: COBRA/EMTALA and Anti-Trust Issues. 3.0 credit hours. Call Sandy Sooter, St. John's Regional Medical Center, Joplin 417-781-2727.

November

7 - *St. Louis*: Intracranial Aneurysms. Call St. Louis University School of Medicine 314-577-8167.

7 & 8 - *Columbia*: 7th Annual Caring for the Frail Elderly Conference. Call University of Missouri 573-882-0366.

7 & 8 - *St. Louis*: 25th Annual Kilo Diabetes Symposium. Current Topics in Diabetes, Endocrinology and Vascular Disease. Call Beverly Cantoni 314-434-6500.

7 thru 9 - *Branson*: Missouri Academy of Family Physicians's Fall Conference. 10 credit hours.

13 & 14 - *St. Louis*: 23rd Annual Symposium on Obstetrics and Gynecology. Call Washington University School of Medicine 314-362-6891.

14 - *St. Louis*: Neurosurgical Endoscopy. Call St. Louis University School of Medicine 314-577-8167.

22 - *St. Louis*: Midwest Clinical Molecular Cardiology. Call St. Louis University School of Medicine 314-577-8167.

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The MPH Program is available statewide. Representatives and services are located in principal urban centers to provide the most convenient access to services.

The Missouri Physicians Health Program has many years of experience in assisting physicians who are experiencing a variety of impairment issues. Access to the most appropriate sources for evaluation and treatment is available. A quality monitoring program is provided which has earned a strong reputation for credibility and therefore, a high degree of reliability in our effort to advocate for any Missouri physician.

A brochure and other educational information concerning the Missouri Physicians Health Program are available upon request. All inquiries are welcomed.

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The MSMA Alliance is a key supporter of the De Novo program. For more information, contact an Alliance member or call the number below.

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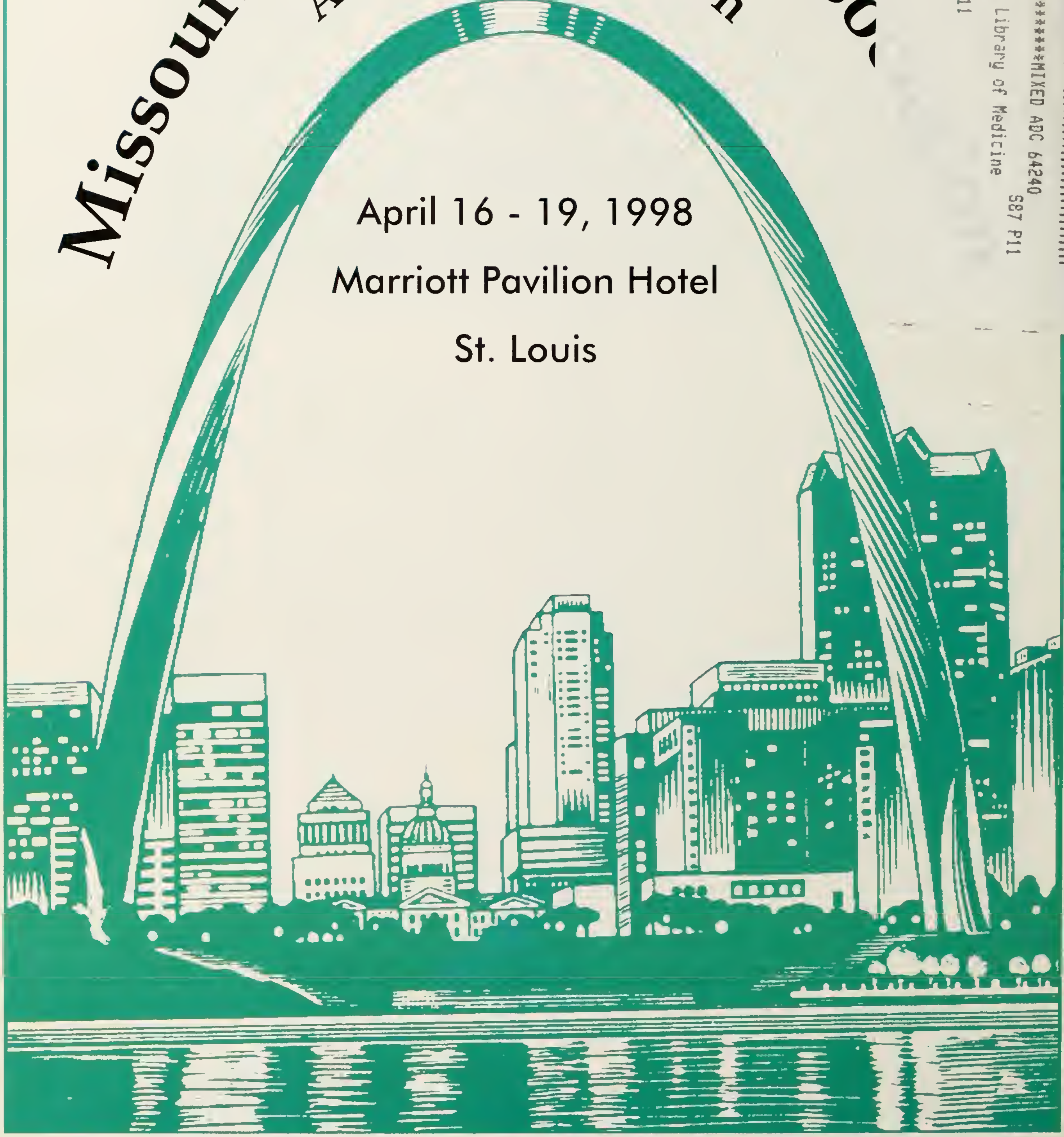

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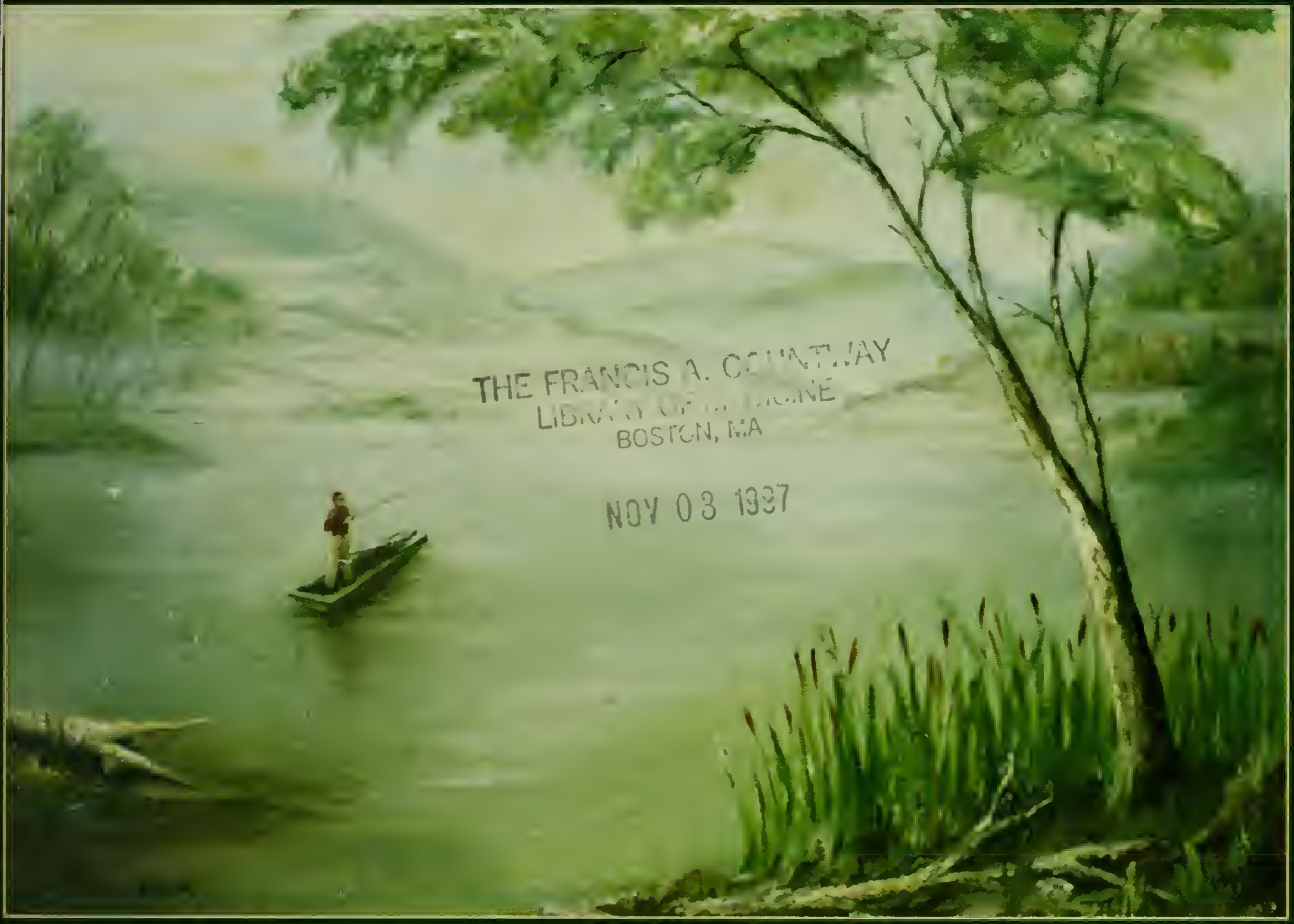

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On the Cover: *"Shadow Valley Lake," by Harold C. Stricker, MD, 1918-1991. This oil painting was completed in September 1969.*

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Considering Environmental Pollution

J. Regan Thomas, MD

Environmental pollution issues periodically gain the attention of the media and thus the attention of the public. Unless there is a massive or dramatic incident like the Valdiz oil spill, the interest by the media and public alike seems to wane relatively quickly. Like so many health issues, we need to think about various forms of pollution with a perspective toward solutions rather than brief, sound bite, blips on the media screen.

USA Today, reported on an international meeting at the Scripps Institute to be held in January. This group will be looking at a major field study of the climatic effects of air pollution. As more countries become industrialized, the possible pollution effects become more complex and more of a concern. The study called INDOEX will study among other factors, the types and amounts of aerosols in the air. No doubt much discussion will be stimulated in the environmental science circle, but how will it affect most of us in a day to day, "real life" way?

As physicians, pollution may impact our patients in very direct ways. For example, studies show that people living near auto traffic show an increase in allergic rhinitis and the nasal-sinus symptoms that accompany it.

You can live without food for several weeks, without water for several days, but without air for only a few minutes.

There has been discussion in recent years about the "Sick Building Syndrome" and various symptoms related to toxins and pollutants that may be within a given work or living space. Some aspects of that situation are controversial, but it is certainly true that some pollutants are more concentrated indoors. An urban community spends most of its time indoors (probably greater than 85% for most people). A recent physician quote tried to put the air quality into perspective. He noted that you can live without food for several weeks, without water for several days, but without air for only a few minutes!

Water pollution is often regarded as a problem for wildlife and fish. But certainly the human population can be affected. In 1993, 400,000 people in Milwaukee were exposed to waterborne disease when cryptosporidium parvum was detected in the drinking water supply. It is estimated that more than 25 million people in the U.S. have no water treatment for their drinking water. The past few weeks have discovered that a single cell organism causing significant disease in fish and shellfish on the east coast apparently can also cause illness in humans. Thus far all identified patients have been fisherman but there is concern that the public at large could be effected.

Pesticides continue to be a concern. Although alternatives to DDT-like organochlorines have been developed, changes in pesticide use may create new problems. Farmers who used to spray once a year with organochlorines may now spray organophosphates multiple times through the year.

As with so many issues that effect the general public health, this one is complex. None the less, physicians must be aware that environmental pollution is more than an esoteric scientific debate. Pollution affects our patients. MoMed

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Using Humor in Medical Practice

A.J. Campbell, MD

"A Merry Heart Doeth Good Like A Medicine But A Broken Spirit Dryeth The Bones"

As we enter the last few years of the millennium, this piece of ancient biblical wisdom is finding scientific support within the medical community, and we as practitioners and members of an increasingly stressful profession have ever more need to hearken back to its message, even as we look forward into the uncertainties in our professional futures.

Norman Cousins first called the attention of the medical community to the potential therapeutic effects of humor and laughter in 1979 when he described his utilization of laughter during his treatment for ankylosing spondylitis. Cousins watched funny movies and cartoons to make himself laugh heartily every day. He proposed that a good belly laugh is like internal jogging. He believed the experience of laughter could open him to feelings of joy, hope, confidence and love . . . and thus promote his recovery.

Cousins spent the last twelve years of his life at UCLA Medical School in the Department of Behavioral Medicine exploring the scientific evidence in support of this belief. He established the Humor Research Task Force which coordinated and supported worldwide research on humor.

As a result of these efforts, we now have proof that laughter appears to be an excellent antidote for stress. For years, stress has been shown to create unhealthy physiologic disturbances including hypertension, muscle tension, and immunosuppression; laughter, on the other hand, creates the opposite effects.

Berk, at Loma Linda University School of Medicine, Dept. of Clinical Immunology, has produced carefully controlled studies showing that the experience of laughter lowers serum cortisol levels, increases the amount of activated T lymphocytes, increases the number and activity of natural killer cells, and increases the number of T cells that have helper/suppressor receptors. In short, laughter stimulates the immune system, potentially offsetting the harmful effects of stress.

Studies have shown that using humor increases one's sense of control over life events and diminishes the feelings of powerlessness that are characteristic of most negative situations and emotions. Humor is often the first thing to go when one is stressed, sad, or angry. Negative emotions turn our focus inward. A sad or angry person cannot see beyond him or herself. Like an inwardly turning spiral, the more caught up we are in our own problems, the more difficult it is to see beyond them. Laughter, on the other hand, turns us outward, and is an avenue to connecting with friends, family, patients, and colleagues.

In the fields in which we work, most of us have been granted the opportunity of caring for a patient who has brought humor - a merry heart - into an otherwise dire situation, and we have observed how such individuals bring levity, but also strength and grace to those around them. We admire and respect those individuals whom we have been fortunate enough to know and care for; we should learn from them as well. Just as humor and joy amidst illness can cause healing of the body and spirit, and as we so often see as well, of families - so too might we as physicians strive to integrate levity into our own lives, in our interactions with our colleagues, our staffs, our patients and, so very importantly, with our families. Our work is hard and often stressful, and OUR good humor is often quick to go. How much more difficult does that make our own lives, and less satisfying and joyful the work and lives of those around us? We came to this honorable profession with genuine commitments to help our fellow person, yet we lose sight of behaving in a healing fashion when we become stressed, angry or lose our sense of perspective and our sense of humor. These considerations also apply in a very real way to how we deal with our fellow physicians. In an era of increasing fragmentation in the profession, might we not hearken back to the biblical admonishment to maintain a merry heart? Might we not offer the flexibility and grace implicit in good humor to those with whom we have differences? A good belly jog might settle more hard feelings and bring more understanding than another 10 board meetings, and would certainly be more fun to try! A broken spirit not only dryeth the bones of the individual, but it has the potential to dryeth the bones of our profession: the bones of collegiality, comradery, and commitment to a common good.

Norman Cousins has taught us the importance of humor. He has also taught us that at times - times which are difficult, and when we particularly benefit from the grace humor brings - we must work to maintain our humor, and must accept responsibility for our own attitudes. Let us each try to remember the joy which laughter and good humor can bring, and to share that with others in the work we are so privileged to have been given. MoMed

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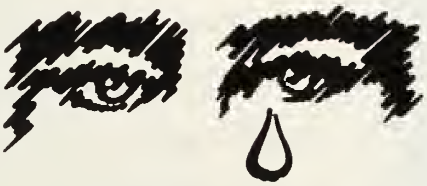
SAVE Today
Stop America's Violence Everywhere

Maura Taylor, Greene County Medical Society Alliance

Physicians are one group of people who don't need to be reminded of the devastating effect of violence on our families, our health care system, and our society. That's why you are invited to help the Alliance SAVE Today . . . Stop America's Violence Everywhere. On Wednesday, October 8, Alliances nationwide will take part in an effort to emphasize grassroots solutions to local problems related to violence.



The Greene County Medical Society (GCMS) Alliance is using this event to focus on the diagnosis and treatment of family violence which includes domestic abuse.

Domestic violence is a disease that affects 28% of all women seen an an outpatient clinic, 10-15% of all women seen in an emergency room, and one out of every four women seeking prenatal care.

According to Barbara Bumberry, MD, Springfield, the diagnosis of domestic violence is missed in 34 out of 35 cases.

"Domestic violence is a pattern of assualtive and coercive behavior used by an individual to hurt, dominate, and control an intimate partner," Bumberry said. "It does not just involve physical abuse. Other tactics can include verbal and emotional abuse, threatening to harm or take away the children, destruction of property, and even sexual abuse."

During October, the GCMS Alliance will be distributing, to physicians, a booklet, *Family Violence: Face the Problem, Heal the Cycle*, with facts and information about the diagnosis and treatment of domestic violence. Also in October, a massive media campaign will begin running on television and in print. Area hospitals will be sponsoring conferences and grand rounds given by physicians with a special interest and knowledge of this issue.

"Although we cannot expect to end domestic violence, thanks to the tremendous efforts of everyone involved in this project, maybe we can at least bring this issue out into the open and start helping abused women and their families get the help and support they so desperately need," Bumberry said.

For more information about SAVE Today programs in your area, contact your county Alliance president. MoMed

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Membership Notes

Gerard "Jay" Harms, Jr.
MSMA Director of Field Services

My first month as Director of Field Services for the MSMA has been one filled with excitement and promise. The excitement has been in the form of new programs for members and recruitment of non-members. We co-hosted with the American Medical Association, the first of hopefully many, Membership Appreciation Day and Membership Drive.

The event took the form of a District #5 Tail Gate Party for the University of Missouri, Columbia's '97 home-opener football game.

The event was widely applauded as a success, even though it was planned in just three weeks. We had hoped for a larger physician response, to include non-members, however a lack of publicity and the short planning time had an effect. We project an increase in the medical student section rolls of eight to 10 new members from this event, and possibly a few new residents. This taken into account with the turn out of current members makes this event a success.

We are also working with the American Medical Association on a number of projects to stimulate exposure and increase membership. We hope to sponsor more Membership Appreciation events, as well as discuss ways to provide more benefits to members while allowing price concessions. These types of programs will be coordinated with the local societies so they are beneficial to all organized medicine.

Our members are proud to be a part of the MSMA. Please, let the non-members around you see this pride.

MSMA has seen an increase in the number of students and residents who see the value of their membership. The rolls of the Medical Student Section and Physician Resident Section have grown enough to give a showing of more MSMA members for the year even though we are down slightly in regular members. At present we have lost 86 physicians this year, but our overall number is up 34 members. This gives us hope in the future that our voice will be heard louder than ever.

MSMA has been taking steps to stop the slide in the regular members. We are now offering to activate non-members when they pay their 1998 dues. By doing this, we can simplify joining at this late time of year, and most importantly, entice non-members to join. The AMA agreed to participate fully with MSMA on this issue and is offering the same promotion. Again, this portends a louder voice and better programs because of a higher number of members.

If there is anything I can do as your Director of Field Services, please let me know! I would like to hear any ideas that you may have regarding your benefits or even ways you think may help membership. I am also available to answer any questions you may have. I may be contacted at the MSMA Office at (573)636-5151, or via e-mail at JHarms@email.PLnet.net .

One thing I would like each of you, our members, to keep in mind is that you are the most effective means for recruitment! In your daily activities, please think of the people around you and ask yourself, "Is that person a member?" If the answer is "no," then perhaps a word about the benefits of membership could be said. Our members are proud to be a part of the MSMA. Please, let the non-members around you see this pride. **MoMed**

Visit our home page:
www.msma.org

Assuring Access to Needed Maternal, Child, and Family Health Services

Nick Boshard, Division of Maternal, Child and Family Health
Missouri Department of Public Health

Restructuring of the health financing and delivery system is occurring at a rapid pace in Missouri and throughout the nation. The Missouri Department of Health (DOH) and its Division of Maternal, Child, and Family Health (MCFH) will continue to play a strong advocacy role for women, children, and adolescents during this period of transition to assure access to needed services for these groups. Central to that advocacy role, is the need to maintain separate standards for women and children as taken from the Public MCH Program Functions Framework: Health Resources and Services Administration, 1995:

> "As a state of human development, childhood differs significantly from the subsequent years of an individual's life span. The health of women, likewise, is influenced by unique biological and social determinants. An approach that addresses the unique needs of the MCH population and provides the MCH expertise within both private and public sectors of the health system must be assured."

A community assessment framework is being put in place that includes broad principles; the division is following to maintain and build those standards:

Principle I:

Families can find the system of care and the system of care can find families who need services.

Principle II:

High quality services needed by women of reproductive age and all children and adolescents, including those with, or at risk, for special health care needs and their families exist in or for the community.

Principle III:

Families are able to use services that exist and feel comfortable doing so.

Principle IV:

The system works to coordinate services for families and works to coordinate itself.

Principle V:

Families are involved in the planning and provision of services.

Standards and policies that grow out of these principles should help build a state infrastructure that supports the integration of categorical programs and their high-risk clients into universal health insurance plans. As more women, children, and adolescents are integrated into mainstream plans and community delivery networks, the MCFH division will work with the provider community to assure that high-risk clients traditionally served by the DOH continue to be linked with the highly specialized services required to meet their needs. The MCFH division will also begin to work with the provider community to begin to create incentives that will encourage mainstream health plans and delivery networks (managed care companies) to enroll more individuals who need specialized high-cost services and to ultimately support more preventive, health promotion, and other primary/population-based services for all women, children, and adolescent groups enrolled in these plans. Certain aspects of managed care hold opportunity for improving public health and the MCFH division will establish partnerships with provider groups to access and leverage managed care networks to provide educational services more extensively and to better integrate the operations of these networks within community prevention efforts.

As an advocate for women, children, and adolescent groups, this division must also acknowledge the reality that many managed care companies have a shorter term vision focused upon expanding member enrollment and rapid generation of profits. The DOH's participating provider network which includes more than 5,000 physicians, may be this division's most valuable resource in choosing network partners that will support accessible care conveniently located, while offering acceptable choices to vulnerable populations of women, children, and adolescents throughout Missouri.

A lengthy transition will ensue, and the MCFH division looks forward to working with the provider community as health delivery and financing systems are restructured in this state. MoMed

Litigation Center Formed

C.C. "Cork" Swarens, MSMA Executive Vice President

The Missouri State Medical Association, 36 other state medical societies, and the American Medical Association (AMA) have formed the American Medical Association/State Medical Society Litigation Center (the "Litigation Center") to represent aggressively the interests of the medical profession in the courts.

The American Medical Association, partnered with the majority of state medical societies, can leverage legal issues in the courts in a way that individual physicians and medical societies cannot do alone. Through the Litigation Center, these partners have joined forces to help physicians counter the powerful challenges they face daily in practice.

The Litigation Center targets advocacy efforts that will broaden the scope of legal remedies available to physicians, aggressively protect physician autonomy in patient care decision-making, and respond to the challenges imposed by the marketplace, government regulation, and political and economic forces. Test-case litigation is targeted to the health care-related legal issues that most significantly impact practicing physicians across the country.

Buttressing litigation efforts are public and media awareness campaigns on significant issues undertaken, negotiations to avoid protracted and costly litigation, *amicus curiae* involvement in third party cases, and in-kind advocacy support (for example, research, expert witness identification, and publicity). The Litigation Center supports patient and physician advocacy efforts and is actively involved in physician education programs.

Litigation Center FY 1996-97 Advocacy Accomplishments

No-cause Deselection from Managed Care Panels: The Litigation Center continues to challenge no-cause physician terminations by managed care organizations through support of two lawsuits which will broaden the scope of remedies available to physicians faced with deselection. The Center and the California Medical Association support plaintiffs in *Martel v. Hill* (challenging no-cause deselection of approximately 300 physicians following a merger involving the physicians' IPA) and anticipate filing an *amicus curiae* brief in support of the *Martel* plaintiffs later this year. The Center and the Texas Medical Association also support plaintiffs in *Zamora v. Health Texas* (alleging that the no-cause termination of a physician based on treatment provided to patients with disabilities is a violation of physician-patient protections under the Americans with Disabilities Act). In *Zamora*, complaints have been filed with the Equal Employment Opportunity Commission, the Department of Justice and the District Court of Bexar County, Texas.

Medicaid Reimbursement Shortfalls in Coverage of "Dual Eligibles": The Litigation Center is assisting its members in seeking appropriate solutions (through negotiation or litigation) of Medicaid shortfalls in reimbursement to providers who serve dually eligible patients, a population consisting mainly of poor elderly, who qualify for Medicaid coverage of their Medicare deductibles and copayments. The specific issues for each state to grapple with is whether and how to: 1) restore Medicaid reimbursement back to 100% of the applicable Medicare rates; and 2) recoup past-due reimbursement. All four appellate court decisions on this issue have ruled in favor of providers. Currently, the Litigation Center is assisting 18 states as they assess appropriate resolution of this issue with their respective Medicaid agencies.

Challenge to ERISA Preemption of Managed Care Negligence: The Litigation Center, along with the Pennsylvania Medical Society and the AMA/Specialty Society Medical Liability Project, filed an

Continued on page 610

Continued from page 609

amicus curiae brief in the case of *Pappas v. Asbel* (Pennsylvania Supreme Court) challenging ERISA preemption of negligence caused by the interference of managed care utilization protocols in the delivery of necessary medical care. The case involved a delay in treating a patient with a neurological emergency, occasioned by the managed care organization's cost-cutting protocols, ultimately resulting in the patient becoming a permanent quadriplegic. *Amici* argued that ERISA does not preempt state laws applicable to ordinary negligence.

Recoupment of Medicare Overpayments to Physicians: The Litigation Center is working with the North Carolina Medical Society and the American Urological Association to challenge inappropriate recoupment by the Health Care Financing Administration of Medicare overpayments assessed against North Carolina physicians. Resolution of this issue is being carried out through a consolidated appeal. The Litigation Center is prepared to file suit to prevent collection efforts by HCFA.

Silent PPO Operations: The Litigation Center continues to educate the provider and payor communities regarding the inappropriate practice by certain third party payors of accessing discounts of indemnity insurance claims through silent brokers. The Litigation Center has identified organizations operating as silent PPOs, is assisting providers investigating silent PPO activity, and is presently working with several potential plaintiffs harmed by these practices who are considering litigating the issue.

Priority of Issues for Litigation

The Litigation Center is committed to a board-based approach in establishing its litigation priorities and emphasizes involvement in those advocacy initiatives that impact the practice of medicine nationally. Consistent with this commitment, the Executive Committee annually solicits its member state medical societies to identify the legal issues that form the foremost concerns of their physician members. Together, the Executive Committee and member representatives establish a priority for action. Cases are then developed or joined in those specific areas.

The Executive Committee recognizes that the relative priority of emerging legal issues will change in response to developments taking place in the health care market. Accordingly, the Executive Committee will review the Litigation Center's priorities issues agenda to ensure that advocacy efforts continually address the highest priority issues. Their success in identifying what are key legal issues will depend in a large part on input provided by the member state medical societies. The Executive Committee and Litigation Center staff will actively seek such input on an ongoing basis.

In addition to litigation, the Litigation Center seeks to carry out its advocacy mission through negotiation, settlement, public education and awareness campaigns, media and public relations campaigns, and joint activity with other medical associations.

These efforts are likely to be centered around the following issues:

- ✓ Managed care abuses (deselection, billing issues, negligent denials of care);
- ✓ ERISA preemption;
- ✓ Hold harmless clauses/provider liability;
- ✓ Utilization review standards (qualifications of reviewers);
- ✓ Patient records confidentiality;
- ✓ Fraud and abuse;
- ✓ Medicare/Medicaid reimbursement;
- ✓ Antitrust;
- ✓ Medical ethics and professionalism;
- ✓ Public health;
- ✓ Silent PPO operations;
- ✓ Americans with Disabilities Act enforcement;
- ✓ Professional liability.

Case Selection Criteria

The MSMA and other founding member state medical societies charged the Executive Committee with developing criteria for determining which cases will be selected for Litigation Center involvement. The Executive Committee will assess the appropriateness of the issue, plaintiff, defendant, and jurisdiction applicable to each prospective case, and will make a determination of case selection by considering the following additional factors:

- ✔ Whether the legal issues presented in a proposed case extend or clarify the case law on a matter of interest to physicians generally.
- ✔ The precedential value of the case (i.e., level of court, jurisdiction, and nature of legal proceeding).
- ✔ The scope of applicability of the case determination (i.e., state, regional, national or specialty-specific matter).
- ✔ The type and level of assistance being requested.
- ✔ The likely chances of succeeding on the merits.
- ✔ The allocation of Litigation Center resources required by the proposed case.
- ✔ The comparative value of selecting a particular case as against other pending and likely litigation needs.
- ✔ The extent of non-financial costs (e.g., whether litigation makes political and other options less feasible).
- ✔ Whether options other than litigation are available, are viable, and whether such options have been pursued.

The Litigation Center is funded by a $1 assessment per member from each participating state medical association and a $250,000 AMA grant. **MoMed**

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Screening for Hemochromatosis Encouraged

James R. Blaine, MD

Approximately one year ago, the Center for Disease Control and Prevention (CDC) in Atlanta issued a concern about the prevalence of hemochromatosis. It seems the disease that most of us thought was relatively rare and confined primarily to men of northern European origin is in fact the most common genetic disease known with a prevalence exceeding one in 250.

We, at the Greene County Medical Society, called the CDC and met Sharon McDonnell, MD, MPH. Dr. McDonnell is the lead researcher for the CDC on Iron Overload Disease; she agreed to come to Springfield to further inform us. She gave two Grand Round presentations (one at St. John's and one at Cox) as well as a talk to the SMSU Health and Human Services Department. She did multiple TV interviews on the subject and then stayed and helped with the Greene County Medical Society all community "Prevention Expo 96."

Statistically, we knew with a population of more than 200,000 in our county we had potentially close to 1,000 people who were undiagnosed hemochromatosis patients. We decided to attempt a mass screening. Our first step was to standardize our four main laboratories to be sure we would have a minimum of false negatives and false positives. Elaine Gunter from the CDC performed the standardization procedure at CDC expense. We then approached multiple potential sources for funding. The only one that agreed to fund a screening so far is Premier Health Plans; Premier is a managed care plan affiliated with St. John's.

Alex Hover, MD, gastroenterologist with St. John's clinics, along with Donna Gloe, EdD, RN, are heading an effort to screen 3,000 St. John's employees utilizing the proven lab test: serum transferrin saturation. The CDC is augmenting their study by providing genetic screening to the same group at no charge.

Dr. Hover's study is vital for several reasons:

1. It will likely demonstrate to local physicians and patients that this easy to treat and otherwise lethal disease is just as prevalent here as the experts in other parts of the country say it is.
2. It will likely demonstrate that it is just as important to screen women as men.
3. It will further help clarify the role of liver biopsy in management.
4. It will point out the need for legislation prohibiting health insurance or job discrimination on the basis of genetic disease.
5. Clarify effect of oral contraceptives on serum transferrin saturation levels.

The following is a Primer that was sent to all primary care providers in the St. John's system.

Primer on Iron Overload for Primary Care Physicians

History

There are several medical conditions that can cause people to develop iron overload. One of these is a commonly inherited condition called hereditary hemochromatosis. It has been recognized for many years; "Bronze Diabetes" (as it was also called) has been described since the 1880s, but until recently, the disease was thought to be relatively uncommon and primarily a condition affecting men of Northern European origin.

Genetic Prevalence

We now know that hemochromatosis is definitely a genetic disease; the actual gene thought to be responsible was discovered in August 1996 by a team of investigators from Mercator Genetics with contributions by hepatologist Bruce R. Bacon, MD, from Saint Louis University. Approximately one in 10 Americans have one copy of the gene and they are called carriers. Approximately one in 250 have both copies of the gene and they have the disease and can develop serious degrees of iron overload. This makes hereditary hemochromatosis the most common genetic disease known.

The Disease

Hemochromatosis causes excess quantities of iron to be absorbed from the small intestine and this can result in the development of a toxic level of iron in tissues. This tends to occur primarily in the liver, but can also affect other organs such as the heart, the pancreas, the joints, the pituitary, and the skin. Undiagnosed, and thus untreated, patients can develop cirrhosis, cancer of the liver, diabetes, heart failure, and other endocrine abnormalities. Symptoms of iron overload cover a wide range and include impotence, hair loss, malaise, lethargy, arthritis, etc., but many patients may be asymptomatic for decades. Statistically, 60% of males and 40% of females will die prematurely if untreated. It is important to note, however, that patients diagnosed with hemochromatosis will not always develop iron overload and it is overload of iron that causes disease to occur in the form of liver cirrhosis, liver cancer, diabetes, etc. Therefore, patients diagnosed with hemochromatosis whether by repeated fasting serum transferrin saturations or by genetic testing will not require any treatment whatsoever unless their serum ferritin exceeds 150.

Screening Tests

The most commonly used screening test is the measurement of the fasting serum transferrin saturation (TS). This is simply the serum iron divided by the total iron binding capacity (TIBC) times 100 (serum iron/TIBC x 100 = TS). Patients should be fasting and off iron supplements for a week and oral contraceptives for a month prior to testing. A TS greater than 50% for a female or greater than 60% for a male is considered positive. All patients with positive values should be retested observing the same fasting parameters and, if the results are still positive, it is thought the patient most likely has hemochromatosis. It is then appropriate to obtain serum ferritin and liver function tests and plan a confirmatory test. Confirmatory tests include quantitative phlebotomy, genetic testing, and liver biopsy. A liver biopsy should be considered if tests of liver function are elevated or if the patient has an enlarged liver. Be sure to check serologies for hepatitis B and hepatitis C if the liver enzymes are elevated. Pertinent patient history includes any history of blood loss (menstrual, blood donations, etc.) and medicinal iron intake. Patients should also be asked about hair loss, arthritis, alcohol history, and impotence.

Treatment

Treatment consists of simple phlebotomy. In older studies, an average patient required 43 units of blood removed over the course of the first year after diagnosis. In more recent studies, when patients are diagnosed earlier, patients can require as few as 10 to 15 units of blood removed in order to have their excess iron stores depleted. Therapeutic phlebotomy should be performed weekly (or twice weekly if the patient can tolerate this) until the ferritin is less than 20ng/ml. Thereafter, once the therapeutic phlebotomy portion has been completed, patients enter into maintenance phlebotomy. For this, one unit of blood each two to three months is usually sufficient to maintain the serum ferritin at a safe level under 50ng/ml. Iron supplements should not be taken and some people feel that a low iron diet is beneficial. Minimizing alcohol intake is also advisable.

Genetic Counseling

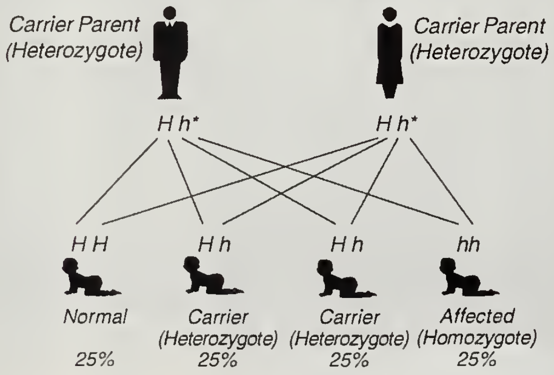
In general, patients should inform all first-degree relatives of the diagnosis and iron studies (fasting transferrin saturation and serum ferritin levels) should be obtained. Consultation with a board certified genetic counselor is suggested.

Recommendations

The following Resolution was passed at the 1997 MSMA Annual Convention:

> *The Missouri State Medical Association encourages all physicians and health plans to include screening for hemochromatosis as a part of routine preventive care and, also encourages the General Assembly to enact legislation that would protect hemochromatosis patients and all patients with genetic disease from employment and insurance discrimination on the basis of genetic information.* MoMed

Segregation of Autosomal Recessive Trait (Both Parent Carriers)



*(h = nonworking gene) 10% of the general population are heterozygotes.

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Radiology Quiz #14

Roger A. Francis, MD
Radiology Department, Lake of the Ozarks General Hospital

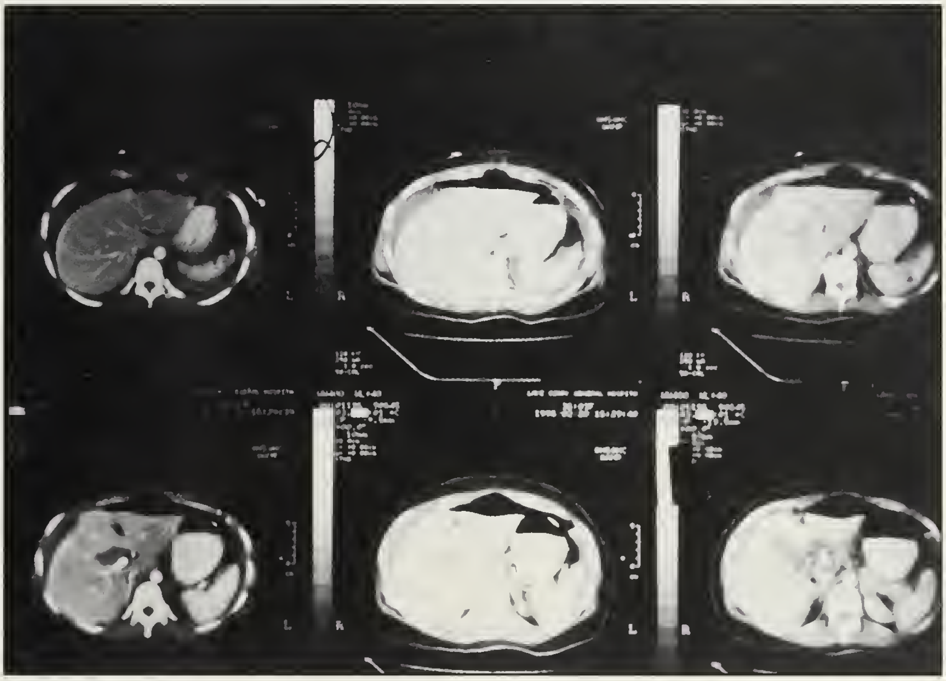

Figure 1

A 36-year-old female was admitted to the hospital after a MVA. She was wearing a seat belt. On admission, no abdominal pain or tenderness was elicited. Approximately 24 hours after admission, lab values included a dropping hemoglobin. A contrast enhanced C.T. scan of the abdomen was performed (Figure 1).

What are your diagnoses?

a. liver and spleen laceration
b. liver and kidney laceration
c. liver laceration and bowel rupture
d. spleen laceration and bowel rupture

(See answer on next page.)

Specialty Quiz Answer

The Radiology Quiz question is located on the previous page.

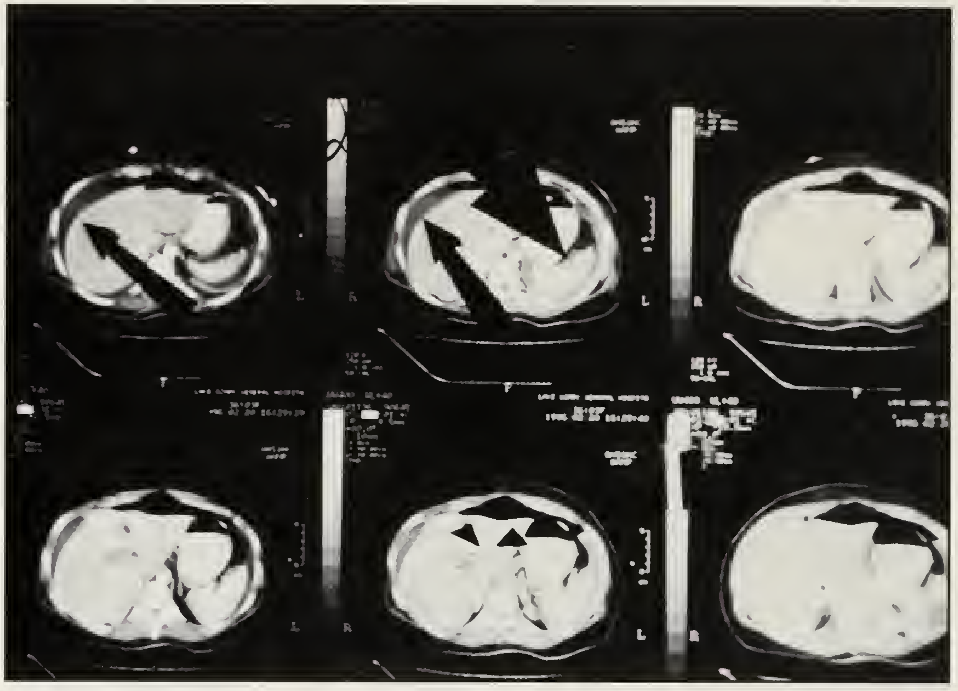

Figure 1 repeated

ANSWER: d. spleen laceration and bowel rupture

C.T. slices show the following findings (Figure 1):

1. There is a large amount of peritoneal air (arrowheads) at the anterior aspect of the upper abdomen. This indicates rupture of stomach or bowel.
2. There is a laceration of the spleen with several linear defects (large arrows) at the anterior lateral aspect of the spleen.
3. There is a large amount of fluid density throughout the peritoneal cavity (small arrows) which may be due to hemoperitoneum or leakage of bowel contents into the peritoneal cavity. The visualized liver appears normal. The kidneys are not visible on these slices and therefore cannot be evaluated.

At laparotomy, major findings included a splenic laceration and rupture of the first portion of the duodenum. Option D is therefore the correct response.

Options A, B and C are incorrect since no liver injury is seen, and no kidney injury can be diagnosed on the images submitted. MoMed

References:

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Independent Physician Associations (IPAs): Regaining Control of Managed Care

Michael A. Wood, MS, MBA

The health care industry is changing rapidly for all health care professionals, but perhaps most profoundly for physicians. Managed care with its emphasis on cost containment, preventive medicine, prospective payment, an increased supply of physicians, and rapid technological change are all influencing physician practices around the nation. These recent structural changes have resulted in a health care system characterized by declining physician incomes and an increasingly difficult environment for physicians to practice medicine at a standard of care for which they were trained. Managed care has created an unbalanced power dynamic between insurance companies, particularly HMOs, and physicians. Physician assumption of financial risk, accountability for health outcomes, increased competition for payor contracts, and a trend toward more and larger group practices have caused physicians to look at alternative methods for meeting the demands and challenges created by managed care. One such alternative is an independent physicians association (IPA).

An IPA is a formal contracting entity that provides medical services through its member physicians to the beneficiaries of health maintenance organizations (HMOs), point-of-service plans (POS), preferred provider organizations (PPOs), and health and welfare trusts as well as self-insured employers and third party administrators. IPAs may have as few as ten physicians or may number in the thousands. IPAs can be multispecialty, single specialty, primary care only or specialist only depending on the market conditions that prevail in any given geography.

Physicians retain control of their individual practices and use the IPA structure as a means of generating part of their income, usually through contracts the IPA negotiates with managed care or indemnity payors. The balance of the physician's income is generated through private pay patients, Medicare and Medicaid.

IPAs and Third Party Payor Benefits

IPAs are extremely appealing to physicians and to third party payors. From the physicians' perspective, IPAs require low levels of capital contribution, they create substantial contracting leverage with payors unattainable by individual physicians and they provide a significant platform for physicians to communicate among themselves as well as with their hospitals, other physician entities, and potential joint venture and capital partners.

Third party payors are attracted to IPAs because they provide a very efficient mechanism to contract with a large number of physicians in a reasonably short period of time. Many of the payors administrative activities such as contracting and credentialling are eliminated due to the fact that most IPAs perform these functions internally. Contract negotiations are often enhanced because IPAs typically have experienced contract analysts and negotiators capable of understanding and developing mutually beneficial contract arrangements. Managed care companies also understand that they will always be limited in their ability to manage individual physician practice patterns. And to be successful, these same companies will have to develop methods to gain physician "buy-in" to managed care that allows them to maintain clinical autonomy and reward them for cost-containment and quality patient care. IPAs provide just such a vehicle to accomplish those objectives. The group dynamic which includes peer-to-peer review, direct involvement in

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quality issues and physician directed clinical management are key components that managed care companies lack when contracting with individual physicians as opposed to IPAs or other groups of integrated physicians.

At the present time, even in moderately managed care markets, one of the key challenges that every practicing physician faces is how to remain financially viable in an increasingly complex and competitive managed care environment. The most obvious result of the rapid penetration of managed care is significantly reduced physician compensation and increased office overhead due to the additional administrative burden of providing services under managed care such as billing, referrals, and preauthorizations. Participation in an IPA often minimizes or eliminates many of the negative effects of managed care.

IPA Stages of Development

IPAs typically fall into one of four categories depending on their stage of development and level of capitalization. They are:

New Startup - IPAs who are not yet formed or have been recently formed but have not created the business infrastructure to support their business operations. New startups may be sufficiently capitalized to operate for a year or better, or they may be capitalized through the startup period with the intention of making ongoing assessments to their members following startup.

Early Stage - IPAs identified in early stage development may have few if any managed care agreements and may still be involved in new startup activities such as credentialling, member contracting, and initial third party payor contacts. Much of the IPAs business infrastructure may be outsourced at that stage of development, or plans for outsourcing have been made contingent upon the IPA successfully negotiating managed care contracts. The typical focus of early stage IPAs is to attract third party payor contracts. Frequently, negotiation of contracts are limited to payors that currently do not have a significant market presence. Incumbent managed care contracts are more difficult to secure and often are not pursued until much later in the IPAs development.

Late Stage in Transition - IPAs that are late stage in transition have typically been very successful in attracting managed care contracts and are in a variety of contracting arrangements that include HMOs, PPOs, Point of Service Plans and in some cases Medicare HMOs. Many IPAs in this stage of development have direct contracting relationships with employers and may even have a unique managed care plan and/or product that they market under their own banner. Although most of the contracts signed to that point involve discounted fee-for-service arrangements, late stage in transition IPAs often have several riskbearing contracts that include capitation, gainsharing, and other reimbursement mechanisms geared toward risk and reward measured by cost and quality parameters. Late stage IPAs in transition are typically migrating away from fee-for-service, non-riskbearing arrangements to capitated riskbearing arrangements that have greater risk and reward. The emphasis on cost containment and quality measures surpasses the focus on fee reimbursement as physicians begin to accept the reality of managing large populations of patients and the cost of care provided to those patients.

Mature IPAs - Mature IPAs have very stable networks of physicians who are capable of managing large numbers of patients on an at-risk basis. Mature multispecialty IPAs often have a very restricted specialty care panel of physicians with an almost equal number of primary care physicians in their network. The ratio of primary care to specialty care physicians in mature networks can be as great as 1:1. The configuration of mature IPAs gain their characteristics from the elimination of high cost physician members, particularly specialists whose patients are reallocated to more cost-effective specialty care physicians in the same network. High cost physicians in mature IPAs are either dropped from the IPA or patients are redirected within the IPA. Mature IPAs typically have comprehensive business infrastructures to support their operations either directly or through outsourcing arrangements. The level of sophistication in managed care contracting is at a very high functional and operational level in mature IPAs. Risksharing arrangements may include all medical cost components except plan administration and marketing. Mature IPAs may include hospital contracting, outpatient services, diagnostic testing and pharmacy services as part of their contracting matrix. Although few IPAs own such facilities directly, they have the ability to become the contracting conduit for non-physician services due to their ability to negotiate and manage comprehensive risk contracts on a seamless basis.

IPA Capitalization and Financial Management

IPAs who have active managed care contracts in force have a consistent cash flow generated by physicians providing patient care to managed care enrollees. However, IPAs have had difficulty harvesting a portion of this revenue stream for their own operations due to management information systems requirements and capital expenditures required to capture and pay third party claims. As such, most IPAs have funded their operations through ongoing membership dues and to a lesser extent by assessing members administrative fees based upon their claim volume as determined by reports generated by the managed care companies that they have contracts with. Many IPAs have implemented participating physician contract provisions which authorize the IPA to deduct administrative fees, usually on a percentage basis from their physician's claims payments to fund operations.

The most common alternative financing mechanisms utilized by IPAs today are as follows:

✔ Membership Dues - Initial and Ongoing
✔ Application Fees
✔ Administrative Fees Deducted from IPA Claims Payments
✔ IPA Network Access Fees Received by IPA from Payors and/or Employers
✔ Surplus Dollars Created from Managed Care Risksharing Arrangements
✔ Group Purchasing Arrangements
✔ Fees Paid by Third Party Payors for Utilization Review, Quality Assurance, Credentialling, etc.
✔ Joint Venture Arrangements with Alternative Health Care Delivery Organizations

Also, as IPAs continue to pursue capitated and other riskbearing arrangements, many third party payors are willing to compensate the IPA for services historically provided by the managed care payor such as claims administration, reporting, credentialling, pre-authorization, etc. This shifting of administrative dollars from payor to provider reduces the IPAs overhead expense.

IPAs offer physicians a variety of benefits and advantages which are often difficult or impossible to attain as solo or small group practices due to economies of scale, lack of contracting leverage, and capital constraints. Some of the more obvious benefits to physician participation are described below.

Managed Care Contracting

Risk arrangements may be negotiated to reward the IPAs physicians specifically for their cost containment efforts. Physician bonus arrangements, decreases in standard withholds and reductions in administrative requirements are examples of plan specific negotiating points.

IPAs provide an important intermediary role between physicians and managed care plans with regard to claims payments, disagreements on precertification/preauthorization protocols, and other managed care administrative tasks and activities.

IPAs are often successful in negotiating the use of in-office laboratory, radiology, and other diagnostic/ancillary services that would ordinarily have to be referred outside of the practice.

IPAs are extremely effective and efficient in analyzing and evaluating managed care fee schedules, capitation payments and related services requirements, risksharing arrangements and third party payor financial stability.

IPAs serve their member physicians by disseminating important financial and operational information about their managed care contracts more concisely and typically more quickly than what is provided directly by the third party payor.

IPAs create negotiating leverage with third party payors unattainable by individual physicians or small groups.

IPAs provide an efficient, cost-effective alternative physician contracting mechanism for third party payors due to reductions in physician/staff solicitation and meeting time, duplication of credentialling activities and individual response to contract specific issues and concerns.

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Marketing

IPAs create a marketing image similar to a large multispecialty or single specialty group practice, but with the benefit of physician autonomy and improved geographic distribution.

IPAs provide an established contracting entity to pursue direct contracting relationships with self-insured employers.

Quality Assurance

IPAs provide a ready vehicle for managing patient quality of care through physician peer-to-peer review on IPA quality assurance and utilization review committees.

IPAs provide a vehicle to develop consensus and innovation by physicians for physicians with regard to medical protocols, use of technology, and evaluation and implementation of alternative patient care delivery mechanisms.

Hospital Relationships

IPAs provide an established entity to communicate and address hospital/physician issues, joint contracting opportunities and further the mutual interests of both the physicians and the hospital.

IPAs are very flexible in that they can contract with third party payors on a stand alone basis, join physician-hospital organizations (PHOs) as a group, and under either scenario create a separate risk pool for its members.

Practice Management

IPAs provide administrative assistance to member physicians in areas such as reimbursement maximization, procedural coding, and OSHA/CLIA compliance.

IPAs can effectively develop group purchasing programs and opportunities that reduce practice overhead expenses. Examples of group purchasing programs include medical, surgical, laboratory and office supplies, group health insurance, medical malpractice insurance, billing and collection services, and banking and other financial services.

Conclusion

As the resurgence in interest in IPAs continues to grow on the part of both physicians and third party payors, further consolidation of IPAs in the form of mergers, affiliations with other health care organizations to form larger integrated networks, and a movement toward increased levels of clinical and financial integration will blur the definition of what an IPA is when compared to its historical function and description. Indeed one of the most significant aspects of recent IPA evolution has been a trend toward more and more efficient handling of greater levels of risk, in many instances at levels that meet or exceed their integrated medical group and staff model rivals.

Critics of IPAs often claim they are too loosely structured, lack sufficient physician leadership and are only marginally successful at altering physician practice behavior and managing risk. As managed care has evolved, physician attempts at starting and operating IPAs has resulted in a broad spectrum of successes, failures and stepping stones to more integrated physician models. Nonetheless, most observers would agree that IPAs are a valuable starting point for physician integration beyond the physician's own individual practice. Successful IPAs will continue their dynamic growth and serve as a key transitional vehicle for physicians who desire greater degrees of integration but wish to adopt to this new managed care paradigm in a logical and graduated basis. MoMed

The Author

Michael A. Wood is President and CEO of Saint Louis Management Group in St. Louis, Missouri, a core partner in PRN. St. Louis Management Group is a national healthcare management and consulting firm which provides turnkey IPA management services including startup, ongoing operations, and managed care contracting services to more than 4,000 physicians nationwide.

The Use of Standard Management Reports In Medical Practice

Part II

Tom Bennett, MBA, MDiv, MSW, GCG
Terry J. Brennan, MBA, FACMPE, FHFMA
N. Rock Erekson, MBA, CMPE

As independent physicians continue to grapple with the complexities of medical practice management, and as they struggle to maintain their income levels, they may find themselves in a double bind. They may be faced with spiraling decreases in revenue due to the reduction in professional fees by health plans, while witnessing a steady increase in overhead expense.

In light of these difficulties, it behooves physicians to become better informed about all facets of their practice, particularly the business side. Unfortunately for smaller practices that do not have the management infrastructure, the only way to achieve this is to either contract out for professional/technical resources, or to hire them into the practice. This will of course add more expense to the practice in the short term, but long term it may be the best investment that a practice has made.

This article is a follow up to one published in the September issue of *Missouri Medicine*. Both of these articles are focused on the topic of revenue and revenue analysis. In particular, this article will discuss the following reports: CPT Code Analysis by Charge and Volume, CPT Code Analysis by Payment and Payor, Charges and Cash by Carrier/Plan, Accounts Receivable Aging Report by Payor Source, and Days in Accounts Receivable.

The purpose of this paper is to assist physicians and their administrative staffs in designing a basic set of reports that can be used to judge the performance of their medical practice based on established standards/targets. The reports should track the key components of the business: production, productivity, revenue, overhead, cost, profitability, growth/market share, and customer/consumer satisfaction.

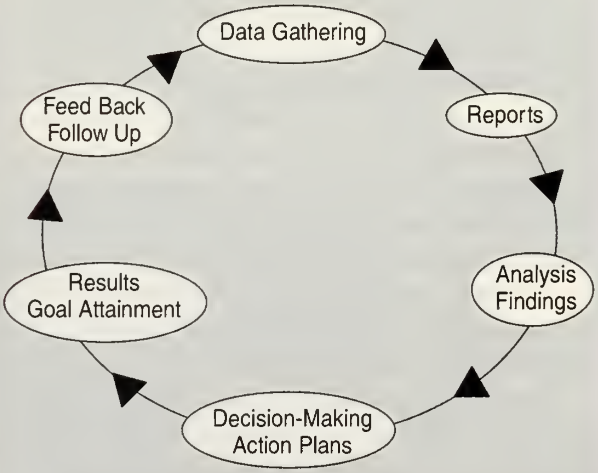
In the midst of all this "socio-economic babble," there is a real danger of losing sight of the primary mission of medical practice: "to provide optimal patient care to patients with the available resources at one's disposal." Hence it is necessary to keep the organization continually focused on the patient and patient care.

The Process

Reporting is not an end unto itself, but rather one step in a multi-step process of achieving results and attaining organizational goals. It should, therefore, be regarded within the broader context of the whole process of change.

Reporting may often be mistakenly regarded as the end point in the change process, when, de facto, it is virtually at the begining. The key steps in the process of change include: data gathering, reporting, decision-making, action-planning, achieving results, and providing feed back. The process is very similar to the Quality Improvement process (Diagram #1).

Diagram #1. The Process of Change (Practice Improvement)



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1. **Data collection.** The beginning point of the process is the collection and entry of the data into the various data fields. This data is generally collected and entered into the computer by the receptionists, schedulers, coders, billers, collectors, nurses, and technicians. In some practices a new position of "info nurse" is evolving.
2. **The Report.** Contingent on the flexibility of the report generator of the billing program, and complemented by the use of a spreadsheet, a set of standard reports should be generated.
3. **Analysis.** The administrative staff should conduct analysis on the reports, and determine compliance with targets/standards/budget and determine the causes of variances/trends. Recommendations should be made and sent on to the Executive Committee and or other appropriate committees for their review and input.
4. **Decision-Making/Action Plan.** The Executive Committee and other committees, after careful review of the findings and recommendations, should make its own recommendations to the board of directors/managers of the practice. It is the board's responsibilty to initiate or endorse action plans based on the findings and recommendations of the Executive Committee or other appropriate/designated committees. However, not all decisions have to be made at the board level, and many could be and should be made at the committee or administrative level.
5. **Results/Achievements.**The end point and purpose of this whole process is to achieve results, meeting the organizational goals and effecting the change that is necessary to create improvement within the practice.
6. **Follow up/Feed Back.**This step completes the cycle by monitoring and assessing the progress or lack of progress of the various directives and action plans.

"I don't care what the reports indicate, or how many charts or graphs you show me, and I don't care what the board recommends. I have been practicing this way for more than 25 years, and I am not going to change now." This refusal to comply may be a typical response from a physician who has been directed by his board to modify his behavior and or practice style. The rapid rate of physician integration further compounds the situation. The issue of compliance has become a complex and thorny one, and without fair, firm, and consistent governance, the authority of the board can be eroded and undermined.

In summary:

- Identify and clearly define the problem.
- Assess the problem and the attempted solutions.
- Clearly define the concrete changes to be made.
- Formulate and implement the plan(s) to produce change.
- Preparation of consequences for non-compliance.[1]

Because of the complexity of this issue its discussion will be deferred to a future article.

MANAGEMENT REPORTS

In order to be consistent with the prior article, the context of this set of reports is a hypothetical multispecialty primary care group: Dr Smith (Internist), Dr Evans (Peds), and Dr Jones (OB/Gyn). Please note: the data in the reports are used for illustration purposes only, and may not reflect current charges/cash receipts, etc.

Report #1
Major CPT Codes by Charge and Volume

Report # 1.
CPT Analysis by Charge and Volume S. Jones Aug 97

Code	Descript	Fee	Vol	Revenue	% of Rev
59400	Vag Del w/c	$2,300	64	$147,499	26%
59510	C-Sect w/c	2,500	28	69,750	12%
99213	Est Pt visit	45	1,166	52,470	9%
57454	Col w/bx	325	117	37,895	7%
99214	Est Pt visit	55	513	28,217	5%
76805	US OB	225	70	15,741	3%
59400	Vag Del HR	2,600	7	18,190	3%
58260	Vag Hyster	2,400	8	19,589	3%
58150	Abd Hyster	2,500	6	14,575	3%
76856	US GYN	250	35	8,745	2%
88155	Pap Smear	25	146	3,644	1%
99203	New Pt visit	65	139	9,019	2%
Sub-total revenue for above codes:				$425,333	75%
Total Revenue YTD 8 months:				$568,000	100%

The purpose of this report is to graphically indicate by CPT code YTD charges that account for at least 75% of the total gross charges for the physician/practice. This report is important because it shows to the physician the mix of activity by specific CPT code, and the opportunities and liabilities that he/she could face if there is a change in these top revenue codes.

With reference to Dr. Jones and this report:

- 12 CPT codes account for 75% of total charges.
- Four CPT codes (59400, 59510, 99213, 57454) account for 50% of his charge activity.
- Two codes (deliveries) account for 38% of total charges.

A negative change in reimbursement rates for these top four codes, or a decrease in referrals could have a major finacial impact on this physician/practice.

This report could be further enhanced by including two other fields: cash receipts by CPT and percentage of total cash receipts by CPT. Adjustment should be made to cash receipts assuming that cash is recieved 60 days after billing date.

Report #2
Major CPT Code Analysis by Cash by Payor

The purpose of this report is to show payments by insurance carrier/plan by the major CPT codes that account for 75% of physician's total charges. As should be noted from this example for Dr. Jones, that for CPT code 59400, which carries a charge of $2,300, there is a range of payments from $690 (Medicaid) to $1,725 (HMO2). Therefore it would behoove Dr. Jones to increase his HMO2 referrals given that this plan pays 75% of charges for CPT code 59400 and 79% for code 59510.

Report # 2.
CPT Code Analysis by Payment and Payor S. Jones Aug 97

Code	Descript	Charge	MCare	MCaid	HMO1	HMO2	HMO3	HMO4	HMO5	HMO6	HMO7
59400	Vag Del w/c	$2,300	$966	$690	$1,495	$1,725	$1,700	$1,680	$1,350	$918	$1,063
59510	C Sect w/c	2,400	1,170	858	1,690	1,950	1,900	1,750	1,500	1,112	1,287
99213	Est Pt visit	45	20	11	32	37	35	32	28	19	22
57454	Col w/bx	325	169	145	295	290	285	245	230	161	186
76805	US OB	225	112	72	146	180	175	160	135	106	123
58260	Vag Hyster	2,400	1,080	960	1,728	1,872	1,776	1,500	1,400	1,026	1,188
58150	Abd Hyster	2,500	1,100	975	1,850	1,900	1,770	1,550	1,500	1,045	1,210
76856	US GYN	422	168	118	295	329	300	295	275	160	185
88155	Pap Smear	25	11	9	22	20	20	19	20	10	12

By adding another field, i.e. volume, this report would be able to demonstrate to the physician/practice the actual cash by CPT code by health plan. This type of detail on a spreadsheet is invaluable when performing analysis for contracting for managed care rates. Because of reasons of space this report does not include all the major carriers/plans by CPT code that the practice does business with.

Report #3
Charges and Cash Receipts by Carrier/Plan

Report # 3.
Charges and Cash by Carrier/Plan S. Jones Aug 97

Carrier/Plan	YTD Charges	% Charges	YTD Cash	% Cash
UHC	$175,000	31%	$110,250	32%
Other	75,880	14%	56,200	16%
HealthLink	45,000	8%	31,500	9%
Medicare	51,120	9%	29,920	9%
Medicaid	68,000	12%	23,800	7%
Partners	35,000	6%	20,300	6%
Hartford	23,000	4%	18,400	5%
Humana	25,000	4%	15,750	5%
GHP	25,000	4%	16,000	5%
BC Alliance	10,500	2%	6,615	2%
Aetna	6,500	1%	3,965	1%
Blue Choice	7,500	1%	4,800	1%
Cigna	7,500	1%	4,650	1%
PruCare	5,000	1%	3,100	1%
Total	$560,000	100%	$346,000	100%

This report is a variation on the Payor Mix Analysis and it indicates the amount of charges and cash receipts by individual carrier/plan. This report for example shows that Dr. Jones:

- has more than 30% of his total practice with United Healthcare.
- that Medicaid accounts for 12% of charges and only 7% of cash.

This concentration of activity with United Healthcare may be a liability for the

Continued on page 624

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physician/practice in the event of a change in reimbursement rate and or a change in referral patterns.

This report could be further enhanced by adding a field to track timeliness of payments by carrier/plan. This added field would track the average days in AR by carrier/plan. This information is important given the current tardiness of some carriers/plans, and the cash flow problems faced by practices due to tardy payments.

Report #4
Acounts Receivable Aging Report

Report # 4.
Accounts Receivable Aging Report by Payor Source
S. Jones Aug 1997

Payor Source	Total AR	% Tot AR	Current	31-60	85% 61-90	75% 91-120	50% 121-150	25% 150 +	Coll. Rate
Medicare	$32,500	14%	$12,000	$6,000	$4,000	$3,500	$2,000	$5,000	44%
Medicaid	32,300	14%	7,800	12,000	5,000	3,500	1,500	2,500	30%
PPO	83,000	37%	32,000	20,000	15,000	10,000	2,500	3,500	63%
HMO	18,050	8%	6,550	5,000	2,500	1,500	1,000	1,500	64%
Indemn	18,000	8%	6,500	3,500	2,500	2,000	1,000	2,500	80%
W/Comp	18,900	8%	3,900	4,000	3,500	2,500	1,500	3,500	90%
Private	23,450	10%	3,250	5,000	4,200	2,300	1,200	7,500	25%
TOTAL	$226,200		$72,000	$55,500	$36,700	$25,300	$10,700	$26,000	
Percentage of total AR			32%	25%	16%	11%	5%	11%	

The purpose of this report is to present the distribution of accounts receivable by payor category by date range (30 day increments), including the overall percentage of accounts receivable. It is meant to be a report on the "collectability" of the accounts. Nota Bene: the older the charges, the more difficult to collect, and the more likely that there will be bad debt write-offs.

With reference to this report for Dr Jones:

- Total AR is $226,000
- 44% is more than 60 days
- $31,000 of AR is more than 60 days for PPOs
- 27% of the total AR is more than 90 days

Accounts receivable are accounted for in "CHARGES," therefore, the practice should devise a method to calculate the expected cash receipts. This can be done by the use of a historical collection rates by payor category (refer to heading of Cash Factor in the report), and a discount factor for the age of the accounts, the older the account the greater the discount. Please refer to the discount factors of 85%, 75%, 50%, 25% which are located at the top of the columns. It should be noted that these discount factors are only estimates.

Example for estimated cash receipt:

- Payor category: Medicaid
- Charges: $ 2,500
- Time range: 150 + days
- Historical collection rate: 30%
    - Discount factor for time: 25%
    - Expected cash receipt: $188 (2,500 x .3 x .25)

Report #5
Days in Accounts Receivable

Days in accounts receivable (DAR) is a standard ratio that is used by many industries to report on the status of an organization's accounts receivable. Days in accounts receivable answers the question: "How long does it take, on average, to collect on one days worth of billing/charges?" The higher the ratio the longer it takes to collect on one days worth of charges.

With specific reference to Dr. Jones and this report: below 70 days would be considered good, 70-80 days fair, and greater than 80 days is rated as poor.[2] Therefore, Dr. Jones' 97 days in AR is rated poorly, and therefore warrants analysis to determine the cause(s).

Calculation for Days in Accounts Receivable (DAR):

1. Time period (Jan-Aug): 243 days
2. The YTD charges for Dr Jones: $568,000
3. The average daily charge for Dr Jones: $2,337 ($568,000/243)
4. The total accounts receivable including current: $226,000
5. Days in AR: 97 days ($226,000/$2,337)

Conclusion

These suggested reports are not written in stone, and should be customized to meet the particular practice needs. However, the underlying principles are constant in that, data, information and knowledge, can greatly assist physicians in making more informed decisions, and coupled with good governance, they can successfully meet the goals of the organization/practice.

"We can yak all we want about improving quality, cutting cost, and increasing value in healthcare delivery, but unless physicians take it upon themselves to lead the charge, it isn't going to happen."[3] This is the ardent belief of Donald Berwin, MD, who is president of the Institute for Healthcare Improvement in Boston. MoMed

The Authors:

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Terry J. Brennan is President of Resource Management Consultants, St. Louis Missouri.

N. Rock Erekson is Executive Director of Metro Heart Group of St. Louis.

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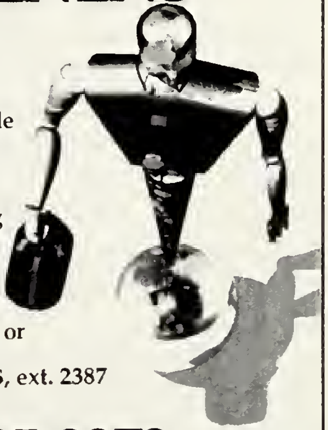

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HMO Financial Data

Source: Missouri Department of Insurance

Table 1. **Missouri - 1996 HMO Financial Data**	**member months**	**HMO Revenue**	**per member per month**	**Total Revenue**	**Med. Loss Ratio**	**Admin. Exp.**	**Net Income**	**Net Income**
*CIGNA Healthplan - St. Louis	92,458	$12,234,069	$132.32	$21,155,488	41%	34%	25%	$5,386,015
CitizensAdvantage	18,421	1,863,399	101.16	1,863,399	118%	16%	-34%	(637,428)
Community Health Plan	88,350	9,796,494	110.88	9,946,250	104%	24%	-28%	(2,789,989)
Exclusive Healthcare (KC)	1,164,305	105,709,638	90.79	104,831,890	93%	16%	-9%	(9,862,729)
Good Health (BlueCare)	343,032	57,686,713	168.17	58,874,671	95%	5%	-0%	(89,678)
Group Health	1,747,663	242,836,380	138.95	250,782,266	89%	17%	-6%	(15,847,706)
HealthcareAmerica Plans	28,297	3,689,177	130.37	3,684,114	91%	19%	-10%	(371,439)
HealthCare USA	796,261	85,702,046	107.63	86,137,405	88%	11%	1%	1,058,134
HealthLink	122,297	14,920,513	122.00	15,377,928	84%	13%	3%	480,242
HealthNet	149,084	21,175,861	142.04	21,793,214	86%	33%	-18%	(3,986,310)
HMO Missouri (Bluechoice)	1,433,967	139,457,523	97.25	147,045,844	84%	19%	-3%	(4,967,450)
Humana Health Plan	8,092,114	1,211,642,037	149.73	1,223,956,614	85%	13%	2%	28,491,563
Humana Kansas City	873,392	163,379,136	187.06	164,963,744	77%	16%	7%	11,149,795
Kaiser of KC	623,720	66,725,064	106.98	69,236,257	95%	24%	-19%	(13,212,312)
Medical Center Health Plan	961,913	103,445,546	107.54	104,956,002	86%	14%	-0%	(115,431)
Mercy Health Plans of MO	403,727	44,046,726	109.10	44,449,962	96%	21%	-17%	(7,579,400)
MetraHealth of KC	132,814	14,344,651	108.01	14,740,301	92%	12%	-3%	(501,331)
MissouriAdvantage	14,204	1,805,847	127.14	1,853,752	89%	24%	-13%	(240,098)
Principal of KC	1,125,479	101,496,058	90.18	107,464,780	95%	18%	-14%	(14,617,239)
Principal of St. Louis	325,761	42,316,043	129.90	43,146,095	91%	18%	-9%	(3,941,016)
Prudential (Prucare of KC)	18,531,753	2,442,019,625	131.77	2,461,759,788	89%	16%	-5%	(129,786,840)
TriSource (BlueAdvantage)	641,161	111,757,926	174.31	112,601,948	96%	13%	-9%	(10,606,955)
United Healthcare Midwest	6,059,884	623,106,039	102.82	639,627,434	92%	13%	-5%	(33,898,170)

* CIGNA's low Medical Loss Ratio is due to a significant amount of Administrative Service Only (ASO) revenue. The corresponding medical expenses for ASO services are not part of the Medical Loss Ratio.

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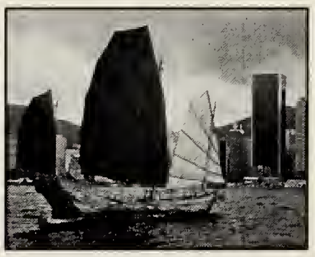

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Clinical Predictors of Domestic Violence

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Domestic violence has become a subject of intense and broad public interest.[7] While we might be reluctant to intervene as physicians,[23] we are under increasing demand to predict such violence so that appropriate interventions can be made and preventive efforts can begin. Additionally, there appear to be duties to warn[3] or to protect[25] endangered persons, depending upon specific legal situations. Despite an ever growing and more sophisticated literature on the prediction of violent behavior within certain contexts,[26] the literature that explicitly focuses on the clinical prediction of violence between intimates is somewhat disparate and inaccessible to the primary care clinician. For that reason, we have reviewed what we believe to be a representative sampling of that literature and combined it with our collective clinical experiences to hopefully offer the family practitioner, general internist, obstetrician, gynecologist, pediatrician, emergency room physician, or other primary care provider some useful guidance in the assessment of the risks for violence in the domestic setting.

We believe it is important for the primary care clinician to be aware that domestic violence is likely to be a recurring cycle. The cycle of domestic violence begins with tension building, then proceeds to the violent act, and is followed temporarily with a period of contrition. Frequently, this cycle repeats with increasingly violent episodes. The perpetrator most often seeks help during the period of contrition, saying that he/she needs help in controlling his/her anger, rage, or temper. This sometimes appears to offer a window of opportunity for the primary care clinician to refer the perpetrator and victim to suitable interventions. Investigation usually reveals that the perpetrator is simply reacting to threats by the spouse to leave, pressure from the family or employer, or the threat of imminent prosecution or jail. All too often, we see that as this pressure dissipates, the perpetrator will be less likely to comply with treatment, prescribed medications, or follow-up. Therefore, the primary care physician might have only one or two interviews in which to elicit the information most crucial to determining the likelihood of future violence.

Since patients are not likely to be forthcoming with detailed information about assaults in the home, and the physician often only vaguely suspects such abuse, we recommend focusing on the following factors during the assessment. We have ranked the various factors in the reverse order in which we believe them to be most significant, i.e., those toward the top being most significant, while those toward the bottom are least significant. We caution that some of these items - especially those toward the bottom - can occur singly or in small clusters in people who do not ultimately go on to become violent in the home or elsewhere. However, when several of these items - especially those toward the top - occur in the same person, we believe that the index of suspicion is sufficiently raised that the realistic possibility of domestic violence should be investigated further and the physician should be prepared to take action.

1. History of violence

It has been widely acknowledged that a history of violence is the best predictor of future violence.[12] Also, a history of having made a violent suicide attempt increases the risk of violence toward others.[4] We recommend that the clinician should especially be alert to a pattern of increasing frequency or escalating severity of violence certainly within the home but also cruelty toward animals, bar fights, assaults against law enforcement officers, or a history of threats or violence at school or work.

2. History of Arrest

Whether for violent crimes or not, a history of having been arrested predicts that the person will likely be

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arrested in the future.[6,10] We believe that having been arrested often represents a disregard for the formal authority of law, rules, and procedures. This can be manifested by a history of bad conduct, dishonorable, undesirable, or other-than-honorable discharge from military service.

3. Substance Use

The use of alcohol, drugs, or both substantially increases the risk of violence in the domestic setting.[2,24] Binge drinking, the use of stimulants (e.g., cocaine, amphetamine, or methamphetamine), or the use of phencyclidine are particularly troublesome. Alcohol or drug use by potential victims substantially increases their risk of victimization. Perpetrators or victims often complain of problems with chronic, ill-defined nervousness, anxieties, or pain for which they often approach the primary care physician seeking antianxiety medications, sleeping medications, or narcotics for such pain.

4. Weapons

The presence of guns, especially handguns,[20,27] semi-automatic or automatic firearms, assault rifles,[8] or the hoarding of any weapons (especially highly lethal weapons - guns or knives such as hunting knives, throwing knives, bayonets, or specialty knives) greatly increases the risk of violence. This both increases the concentration of lethal objects but also reveals a preoccupation with instruments of violence.

5. Violent Sexual Fantasies or Acting Out

This might include a history of marital rape, coerced sexual activity with others,[21] or violent sexual fantasies or sadomasochism. We see this as indicating not only a propensity toward harmful sexual behavior but also the devaluation of the victim as an object to be used and discarded rather than as an equal, consensual partner. While the stereotypic victim of violent sexuality is a woman, one should not ignore that men are also victims of sexual assaults.[14]

6. Efforts to Dominate, Control, or Intimidate Potential Victim(s)

We are inclined to believe this is highly related to the risk of domestic violence. This can take the form of demeaning the victim(s), attempting to isolate the victim(s) from family or social supports, violating an ex parte order of protection, or threats, which might be viewed as a special type of this kind of behavior. We highly recommend that all threats, even veiled ones, be taken seriously. We also believe it to be a warning sign when the male insists on being present while the female, for example, is being examined by the physician. This might apply to other analogous situations.

7. Reckless Driving

This appears to relate to future aggression[18] and represents a serious disregard for the safety of ones self and others, such as passengers, pedestrians, other motorists, and passers by. This might appear as a history of several motor vehicle (including motorcycle) accidents, or the mishandling of other dangerous machinery.

8. History of Psychiatric Illness, Paranoia or Morbid Jealousy

Psychiatric patients who become violent are most likely to attack family members.[16] A history of ten or more psychiatric admissions[12] is associated with future violent behavior. Psychiatric conditions that seem to be associated with future violence include head injury or other forms of brain damage, dementia, impulsivity, and anger control problems. Schizophrenia, especially paranoid type, appears to be associated with a greater risk of violent behavior.[28] This might be especially related to the paranoid symptoms of threat control override (i.e., feeling that others wished one harm, that one's mind is dominated by forces beyond one's control, and that others thoughts are being put into one's head).[13] Other problems that appear to be associated with violence include depression in either victim(s), perpetrator(s), or both; delusions of infidelity; delusions of misidentification;[22] antisocial personality disorder;[9,10] and, a combination of intellectual impairment and antisocial personality disorder.[11]

9. Violence Seen as Being Acceptable

This might result when someone has been reared in an environment in which violence is valued as a means of settling disagreements, disputes, or asserting oneself. For example, it might happen given a history of having been abused as a child, witnessing domestic violence in the home of rearing, or having been brought up being taught that violence is an acceptable and necessary method to deal with situations. We suspect that an excessive interest in violence as portrayed in media might also indicate a morbid acceptance of violence.

10. Excessive Preoccupation with Military or Paramilitary Matters, Law Enforcement, Religious Cults, Survivalism or Martial Ar ts Training

We believe this infers a loss of internal control for which the person is struggling to compensate by seeking sources of external control. Such persons are more apt to act out violently when challenged.

11. Rigid Adherence to Gender Stereotypes

It has been our experience that men who have an excessively macho view of the world (e.g., excessive preoccupation with violent sports, hunting, male-bonding, cars) also tend to denigrate women (e.g., my old lady, lewd comments toward or about females). We believe that this pattern is related to violence toward females. We have also observed that tattoos - especially in large numbers, those with a violent theme, or homemade tattoos - also seem to be associated with future violence. We suspect that a pattern of repeated marital infidelity is associated with male aggression in the domestic setting. However, we caution that the literature is unclear as to the role of hypermasculinity in domestic violence.[19,21]

12. Excessive Self Importance

Also called narcisissm, this reflects the extent to which the person views him or herself as the center of events and importance. This is often experienced as the person having a pervasive sense of grandiosity. Narcissistic persons require excessive admiration, lack empathy toward others, expect favorable treatment or automatic compliance with their demands, and take advantage of others to achieve their own ends. They are often envious of others or believe that others are envious of them, and show arrogant, haughty behaviors or attitudes. We believe that such persons are more likely to take offense at seemingly trivial matters, and react with rage if their self-perceived needs go unmet.

13. Events Seen as Being Outside of Control

This occurs when the person attributes events to processes outside of his or her control. That is, you (or they) are doing things to me and I am reacting to what you (or they) are doing. Extreme forms of this might include paranoia or delusions of threat control override.[13] Such perpetrators believe they are reacting to threats, and often see themselves as the victims. This sense of events being outside one's control also might apply to certain actual victims. For example, some victims of abusive relationships believe they do not have the strength or autonomy to leave the relationship because events are outside their control.

14. Stress(es)

Almost any stressful event can contribute to the commission of crime,[5] of which violence can be a part. Stresses can come from a variety of sources such as marked differences in the ages, self esteems, socioeconomic or educational levels of the perpetrator(s) and victim(s),[1] marked job instability, educational instability, failure to support economic obligations (e.g., child support), significant debt, marital discord, current or recent pregnancy in the female,[15] or other health problems.

15. Victim Characteristics

We do not wish to convey that victims are in any way responsible for their abuse. However, we have found that certain circumstances seem to put victims at much greater risk. For example, vulnerable, dependent victim(s) - most frequently seen with children, elderly, or the disabled - are often abused. Alcohol or drug use by the victim(s) increases a potential victim's likelihood of abuse. Pregnant or post-partum women are statistically more likely to be assaulted,[15,17] especially in the head or abdomen. At least one study points out that women who are more educated, more verbal, or more capable than their mates are also at higher risk.[1] The physician should be especially alert to the suspected victim who makes excuses for, or is overly compliant with, the putative abuser. Also, one should not ignore the possible role of someone instigating violence by somehow challenging, insulting, or otherwise attacking the offender. This apparent

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diversity of victim characteristics suggests that victims are often damned if they do and damned if they don't. This further supports the general notion that victims at most contribute only minimally to their own abuse.

Final Comments

We have attempted to review and summarize the literature on the clinical prediction of domestic violence in order to make predictions easier so that victims and perpetrators can be referred to suitable intervention (such as that required by law) or at least placed under increased scrutiny, such as an increased frequency of office visits, more frequent physical examinations, or more careful questioning. We caution the reader that we intend our efforts to be useful only in raising clinical suspicion such that further careful investigation is done. We recommend that the primary care physician should inquire about the elements of our listing in every patient. We believe that with such increased vigilance should the physician determine that domestic violence is occurring, the patient/victim should be strongly counseled to leave the abusive relationship. It is but a counsel of despair that it may take repeated attempts to leave an abusive relationship before the victim is finally able to leave completely. MoMed

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The Causes of Hemoptysis Revisited

A Review of the Etiologies of Hemoptysis Between 1986 and 1995

George Reisz, MD; Damien Stevens, MD
Christine Boutwell, MD; Venu Nair, MD

Introduction

There are many well-known etiologies of hemoptysis, and the most common causes of hemoptysis have changed.[1-8] Previously tuberculosis, bronchiectasis, and bronchogenic carcinoma were the leading causes of hemoptysis.[1-7] In 1989, our group published a study looking at the causes of hemoptysis in patients undergoing bronchoscopy from 1978 through 1985.[8] Bronchitis and cancer were the most common causes in that study. It was also noted that there was a significant decline in tuberculosis and bronchiectasis causing hemoptysis when compared to previous studies. More recent studies have focused on specific groups such as HIV infected patients or patients from non-industrialized countries, and these results may not be applicable to a general adult population in Missouri.[9,10]

Since 1985 tuberculosis and HIV infections have increased in the population.[11] Like similar institutions, we care for many more patients with HIV and tuberculosis now compared to the time of our initial study (1978-1985). We wanted to know if these or other changes had altered the relative frequency of underlying causes of hemoptysis. To answer these questions we performed a study of the causes of hemoptysis from 1986 to 1995 at the same institution and using the same study method as our previous study.

Methods

A retrospective chart review was performed at Truman Medical Center West in Kansas City, Missouri. This institution is an adult, general, teaching hospital with a large indigent population. All inpatient and outpatient bronchoscopies performed between January 1986 and December 1995 were reviewed. Charts of patients undergoing bronchoscopy because of hemoptysis of unknown etiology were reviewed, and collected data included age, sex, rate of hemoptysis, chest roentgenogram interpretation, acid fast bacilli smear and culture, fungal serology and culture, bacterial culture, smoking history, cytological examination, biopsy interpretation, coagulation studies, and final diagnosis.

Abnormal chest roentgenogram interpretation was defined

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Table 1. Causes of Hemoptysis from 1986 to 1995 (288 Episodes)

CAUSE	No.	(%)
Bronchitis	76	(26)
Malignancy	73	(25)
Bronchogenic Carcinoma	67	(23)
Metastatic Cancer	4	(1)
Lymphoma	2	(0.7)
Pneumonia	29	(10)
Mycobacterial Infection	24	(8)
Tuberculosis, active	12	(4)
M. Tuberculosis, inactive	11	(4)
Avium-Intracellulare	1	(0.3)
Trauma	10	(3)
Post-Surgical	5	(2)
Coagulopathy	4	(1)
DIC	2	(0.7)
Waldenstrom's	1	(0.3)
Uremia	1	(0.3)
Pseudohemoptysis	10	(3)
Laryngeal Carcinoma	3	(1)
Sinusitis	3	(1)
Gingival Bleed	1	(0.3)
Malingering	1	(0.3)
Epistaxis	1	(0.3)
Oral Ulcer	1	(0.3)
Pulmonary Embolism	4	(1)
Chemical Pneumonitis	3	(1)
Lung Abscess	3	(1)
Papilloma	3	(1)
Bronchiectasis	2	(0.7)
Congestive Heart Failure	2	(0.7)
Hemosiderosis	2	(0.7)
Idiopathic Fibrosis	2	(0.7)
Wegener's	2	(0.7)
Alveolar hemorrhage	1	(0.3)
Aspergilloma	1	(0.3)
ARDS	1	(0.3)
Aortobronchial Fistula	1	(0.3)
Blastomycosis	1	(0.3)
Foreign Body	1	(0.3)
Goodpasture's	1	(0.3)
Histoplasmosis	1	(0.3)
Lupus Pneumonitis	1	(0.3)
Mediastinitis	1	(0.3)
Sarcoidosis	1	(0.3)
Silicosis	1	(0.3)
Telangiectasia	1	(0.3)
Unknown	21	(7)

Continued from page 633

as any findings other than changes consistent with chronic hyperexpansion. Hemoptysis rate was quantified as small (<20 mL/24 hours), moderate (20-200 mL/24 hours) and massive (>200mL/24 hours). Bronchitis was defined as erythema, edema, and vascular engorgement with no other disease process. Pseudohemoptysis was defined as bleeding anywhere above the vocal cords, hematemesis, or factitious bleeding. Bronchiectasis was diagnosed by a consistent roentgenogram or computerized tomography and no other cause of hemoptysis. Active tuberculosis was diagnosed by positive mycobacterial culture while inactive tuberculosis was diagnosed if the patient had a history of tuberculosis or a compatible chest roentgenogram and a negative acid fast bacilli culture.

A review was performed on the follow up of patients who had no cause found for hemoptysis. These charts were reviewed for length of follow up as well as any subsequent diagnosis that would explain hemoptysis.

A chi square test was used to compare the most common causes of hemoptysis in this study to the results of our previous study.

Results

There were 296 bronchoscopies on 288 patients performed for hemoptysis of unknown cause. Eight of the patients required a repeat bronchoscopy for a second separate episode of hemoptysis. All patients requiring repeat bronchoscopy for the same episode were recorded as a single study. Eight charts were not available for review. A total of 288 episodes were reviewed.

Patients ranged in age from 16 to 88 with a mean age of 51.8 years. Of the patients, 63.9 % were male and 36.1 % female.

Table 1 shows all causes of hemoptysis in our study. The most common causes were bronchitis, bronchogenic carcinoma, pneumonia, and tuberculosis.

We did not find any cause for hemoptysis in 21 patients. Of these 21 patients, 6 patients had no follow up at our institution. The remaining 15 patients were followed for a mean of 27.3 months. No other etiology for hemoptysis was found in these patients.

The rate of hemoptysis was quantified in 246 of the 288 episodes. The causes of hemoptysis were then subdivided according to the rate of hemoptysis, and these results are shown in Table 2.

Table 3 shows the results of the chi square comparison to our previous study. There were no significant changes in the causes of hemoptysis.

TABLE 2. Etilogy Grouped by Rate of Hemoptysis

CAUSE	SMALL	(%)	MODERATE	(%)	MASSIVE	(%)
Bronchitis	65	(31)	9	(26)	1	(4)
Bronchogenic Carcinoma	51	(25)	7	(20)	10	(43)
Pneumonia	26	(12)	2	(6)	1	(4)
Tuberculosis	15	(7)	3	(8)	5	(22)
Trauma	10	(5)	0		0	
Post-Surgical	4	(2)	0		1	(4)
Coagulopathy	2	(1)	1	(3)	1	(4)
Pseudohemoptysis	7	(3)	2	(6)	1	(4)
Lymphoma	0		2	(6)	0	
Papilloma	3	(1)	0		0	
ARDS	1	(0.5)	0		0	
Aortobronchial Fistula	0		0		1	(4)
Histoplasmosis	1	(0.5)	0		0	
Alveolar Hemorrhage	0		1	(3)	0	
Sarcoidosis	1	(0.5)	0		0	
Blastomycosis	0		0		1	(4)
Lung Abscess	3	(1)	0		0	
Chemical Pneumonitis	0		2	(6)	0	
Congestive Heart Failure	2	(1)	0		0	
Mediastinitis	0		1	(3)	0	
Pulmonary Fibrosis	1	(0.5)	1	(3)	0	
Hemosiderosis	0		1	(3)	0	
Wegener's	1	(0.5)	0		1	(4)
Goodpasture's	1	(0.5)	0		0	
Aspergilloma	2	(1)	0		0	
Foreign Body	1	(0.5)	0		0	
Silicosis	1	(0.5)	0		0	
Pulmonary Embolism	3	(1)	1	(3)	0	
Bronchiectasis	2	(1)	0		0	
M. Avium-Intracellulare	1	(0.5)	0		0	
Telangiectasia	0		1	(3)	0	
Lupus Pneumonitis	0		1	(3)	0	

Table 3. Comparison of Most Common Etiologies 1977-1985 versus 1986-1995

	1977-1985 (%)	1986-1995 (%)	Chi Square Analysis
Bronchitis	55/148 (37)	76/288 (26)	N.S.
Bronchogenic Carcinoma	28/148 (19)	67/288 (23)	N.S.
Pneumonia	8/148 (5)	29/288 (10)	N.S.
Tuberculosis	10/148 (7)	23/288 (8)	N.S.

Discussion

It is likely that the causes of hemoptysis will vary with the characteristics of the population studied (percent smokers, age, etc.). Our present study used the same methodology and the same population as our previous study, and that comparability allows us to focus on whether significant changes have occurred over the past ten years. There was no significant change in the relative frequencies of the most common etiologies of hemoptysis. Bronchitis and bronchogenic carcinoma were once again the leading causes of hemoptysis, whereas bronchiectasis remained an infrequent cause of bleeding.

Similar to the previous study, the rate of hemoptysis did not correlate well with the underlying etiology. There were 24 cases of massive hemoptysis with several different etiologies. One patient expired from an aortobronchial fistula, and another expired from hemoptysis caused by bronchogenic carcinoma.

There was a positive smoking history in 99% of bronchogenic carcinoma patients with one patient not having his smoking history documented. An abnormal chest roentgenogram was found in 98% of patients with bronchogenic carcinoma. Eighty-eight percent of bronchitis patients were smokers.

There were eight HIV infected patients in our study. Their causes of hemoptysis included histoplasmosis, bronchitis, tuberculosis, bacterial pneumonia, and pneumocystis pneumonia. An infectious cause was found in all eight HIV infected patients. Two of the twelve active cases of tuberculosis and the one case of M. Avium-Intracellulare were in HIV infected patients. Although our number of HIV infected patients was small, our findings are in keeping with a larger study of HIV infected patients with hemoptysis that found infectious etiologies, specifically non-tuberculous bacterial pneumonia, the most common cause of hemoptysis in HIV infected patients.[9]

Our study has limitations. It was a retrospective review. All patients with hemoptysis may not have been referred for evaluation. Even with these limitations we believe this study gives an accurate perspective of the relative causes of hemoptysis in an urban North American adult population. Even though there have been significant increases in tuberculosis and HIV in the past decade, that change has not made a significant impact on the relative frequency of the causes of hemoptysis at our institution.

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Ira J. Kodner, MD, was recently installed as President of the American Society of Colon and Rectal Surgeons (ASCRS) for 1997-98 at its annual business meeting in Philadelphia. Dr. Kodner is Director of Colon and Rectal Surgery at Barnes-Jewish Hospital, St. Louis, Washington University Medical Center, and is a Washington University School of Medicine Professor of Surgery.

William D. Owens, MD, St. Louis, will be installed as President of the American Society of Anesthesiologists at the societies annual meeting in October.

Susan E. Mackinnon, MD, Chief of the Division of Plastic and Reconstructive Surgery at Washington University School of Medicine, has been named the first Shoenberg Professor of Plastic and Reconstructive Surgery at Barnes-Jewish Hospital. The endowed professorship was created by a gift from the Shoenberg Foundation to the Barnes-Jewish Hospital Foundation.

John C. Hagan, III, MD, has been elected President of the Missouri Society of Eye Physicians and Surgeons. Dr. Hagan has been practicing ophthamology in North Kansas City since 1975. He is currently on the editorial board for *Missouri Medicine*.

O. Allen Guinn, III, MD, was recently featured in the *Jackson County Journal* for his use of leeches to restore regular blood flow to injured areas. A specialist in plastic and hand surgery, Dr. Guinn frequently applies leeches in cases of venous congestion where damaged veins have trouble returning blood to the heart.

In Memoriam

Robert L. Newman, MD, 84, Kansas City, died July 30, 1997. Dr. Newman, an obstetrician/gynecologist, received his medical degree from the Kansas University School of Medicine. He was a member of theAmerican Medical Association and the Missouri State Medical Association.

Marvin E. Roehrs, MD, 74, Marshall, died August 3, 1997. He received his medical degree from Washington University in 1951 and began his medical practice in Marshall in 1952. Dr. Roehrs was a member of the American Medical Association, Missouri State Medical Association, and the Saline County Medical Assocation.

Pierre W. Keitges, MD, 63, Kansas City, died August 5, 1997. Dr. Keitges receved his medical degree from Creighton University School of Medicine and completed his training in pathology at Ohio State University and the Institute of Pathology at Case Western Reserve University. He was a member of the Missouri State Medical Association and the Metropolitan Medical Society of Greater Kansas City.

Williston P. Bunting, MD, 81, Kansas City, died August 16, 1997. He attended the University of Kansas and the University of Missouri and received his medical degree from the Univeristy of Pennsylvania Medical School. Dr. Bunting, an otolaryngologist, was a member of the Missouri State Medical Association.

Lawrence L. Hyde, MD, 67, Kansas City, died August 20, 1997. Dr. Hyde, an ophthalmologist, was a member of the Missouri State Medical Association.

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Missouri Medicine

Journal of the Missouri State Medical Association November 1997

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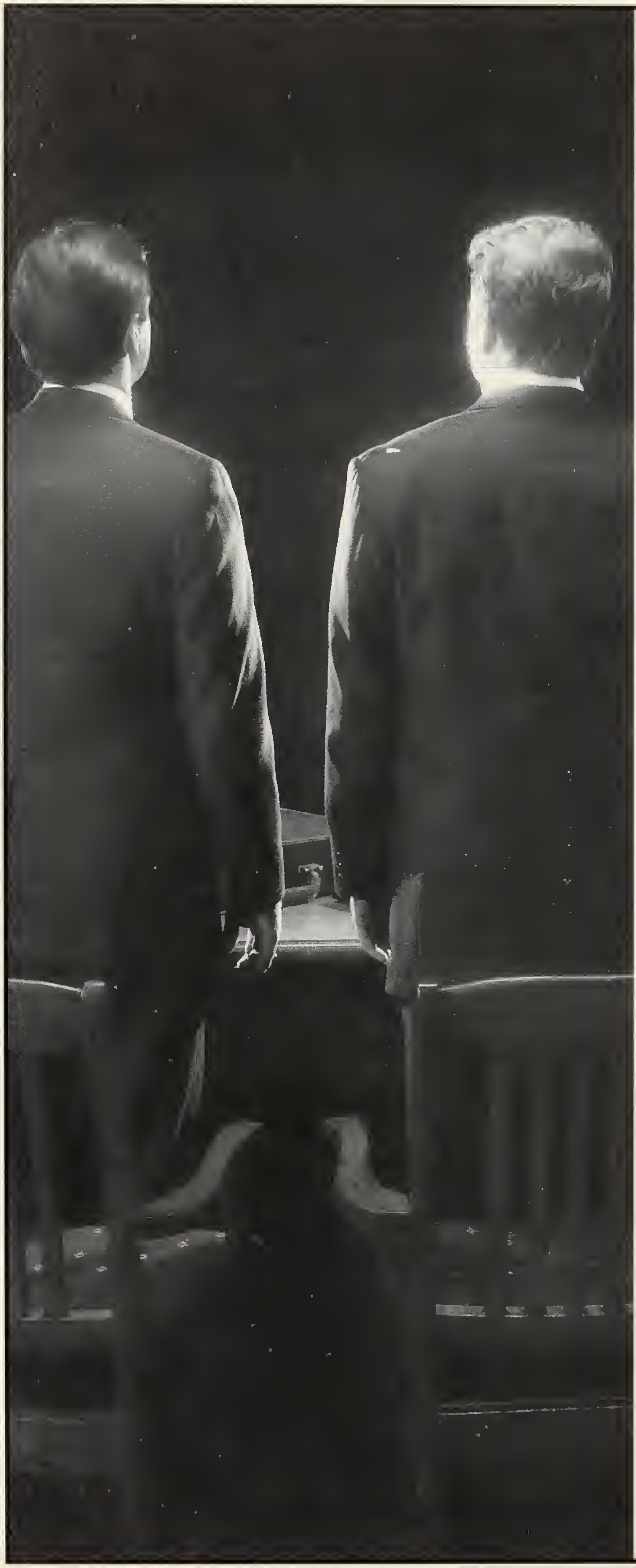

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Cold Relief

J. Regan Thomas, MD

Last month researchers from the Medical University of South Carolina presented the results of a study related to treatment of the viral cold. The results were presented at the meeting of the American Society for Microbiology and financed by the Boehringer Ingelheim Pharmaceutical Company.

Your patients are likely to be asking for the new medicine that "cures" the cold. That's how the story was presented by many in the popular media. Unfortunately there are two problems. First, the medication is likely years away from being on the market. Second, the drug does not "cure" colds, it only helps diminish the symptoms.

Here is how it works. There are hundreds of viruses that cause colds including rhinoviruses which cause about half of them. Most of these invade the body through the nose where they attach to proteins on the surface of the nasal mucosa. The new drug is a genetically engineered protein which attracts the virus and binds it so it is not available to bind with the nasal mucosal cells. The drug is presently called ICAM-1 (intracellular adhesion molecule-1) and can be produced in commercial volumes through gene splicing. The protein is introduced into the nose in spray form and reduces the severity of the cold symptoms by a reported 50%.

A recent Associated Press (AP) report described the study. One hundred seventy-seven volunteers were exposed to rhinovirus and then treated with ICAM-1 spray either seven hours before the exposure or 12 hours afterward. The patients were queried about their symptoms. None of them were prevented from getting a cold, but all felt it reduced their cold symptom severity by 50%. If that is true, it works better than present day treatments (i.e. antihistamines) which typically are rated as relieving cold symptoms by about 30%.

When this new treatment becomes available, it will ease the pressure to use antibiotics inappropriately for viral symptoms

Occasionally, colds are a precursor to more severe ailments and exacerbate other infections. Usually though, a cold is a cold. It makes you feel terrible, but is self-limited and you get through it even without treatment. On the other hand, it is ubiquitous in nature and always seems to occur at the most inopportune times. Millions of cold sufferers will welcome and anxiously pay for some real relief. Most all physicians will welcome the ability to have a new and significant weapon against this frequent viral aggravation.

The more important benefit has not so far been suggested in the news stories I have seen, however. When this new treatment becomes available, it will ease the pressure to use antibiotics inappropriately for viral symptoms. Drug resistant bacteria are continuing to become more problematic. One of the concerns has been the frequent use of antibiotics for viral disease including colds. Having an alternative, especially one that really works, is a valuable tool in avoiding improper antibiotic utilization.

So let's hope ICAM-1 or related drugs come to be available soon. Preserving antibiotic effectiveness for more serious illnesses is nothing to sneeze at for any of us. MoMed

Rexall International Replies

Damon DeSantis
President, Rexall Showcase International, Inc.

I am writing this letter to correct some misconceptions contained in the article entitled, “Pyramid Schemes and Ethics,” by Don G. Fortin, MD, which appeared in the September 1997 issue of *Missouri Medicine*. Rexall Showcase International, Inc. is the direct sales division of Rexall Sundown, Inc., a publicly traded manufacturer of vitamins and nutritional supplements whose *Sundown*® brand is the #1 selling broadline brand of vitamins in the U.S. based on retail unit sales. For an Annual Report of Rexall Sundown, Inc., please call 561-994-2090.

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Student Membership: Recruitment Issues Affecting an Underutilized Resource

Jason Burns
MSMA-Medical Student Section

Over the past few years MSMA medical student membership has grown, increasing more than 30% this past year. Still, despite these successes, student membership remains a relatively untapped resource. Less than 40% of Missouri allopathic medical students are members of MSMA. Although much of the burden of recruitment falls on local medical school chapters, a large part must also fall on MSMA as a whole. The medical student section is important, and has the potential to provide a strong foundation of future physician members. With the growing influence of specialty organizations, it is becoming increasingly important to gain students' interests before they enter into their careers.

It would be foolish to deny the impact that state societies have on medical practice.

Why has such a small percentage of Missouri medical students joined MSMA thus far? Perhaps one reason is the large number of out-of-state students attending Missouri medical schools. I have been told that it is difficult to recruit these students into MSMA since they will most likely be leaving Missouri upon their graduation. Despite this narrow outlook, state medical societies offer a chance to learn about organized medicine, an entity that will have profound influence over these students wherever they choose to practice medicine. Wherever physicians practice, state medical societies play a large role in defining medical care. Whether it be through the promotion of medical legislation or through the development of various services to assist/support physicians on an individual level, it would be foolish to deny the impact that state societies have on medical practice.

Another issue that surfaces during student recruitment discussions is that of visibility. One would be hard pressed to find anyone in medicine who is unaware of the AMA or its purpose. In contrast, state medical societies are often more nebulous entities in the minds of medical students. As a senior medical student, I continue to encounter classmates who are unaware of MSMA. The question then becomes, "Are we doing everything possible to get the word out about MSMA and its role?"

A major difficulty in acquiring student members is the issue of student needs during medical school. Often younger students are not concerned about the cost of membership. Instead they are often faced with the decision of whether or not to join an unfamiliar organization to which they may have little time to devote. These students often fear becoming overextended and losing their focus on academic responsibilities, such as those long forgotten biochemical pathways we all cherished during our preclinical years. Moreover, many students are at a point in their education where they have little insight as to how organized medicine will affect their future practice. Older students who may not have enlisted as freshmen may be reluctant to join in their remaining years due to time constraints and/or their impending graduation and possible change of residence. Regardless of their reasons, it is important to be aware of organized medicine, for medicine and the control of patient care is increasingly being taken from the physician and given to private insurance companies and the government. As a medical student, the opportunity to join a state medical society is an opportunity to learn and become familiar with organized medicine and its processes; yet another step in a lifetime of learning. MoMed

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Spread the Word . . . De Novo is Here

Kathryn Lucas

Finally, the word is beginning to spread . . . at least in Missouri. The word is De Novo. De Novo is adapted from a Latin phrase and refers to that which is new . . . in this case, new understanding, new insight, new hope for a better future. De Novo is the name of a compassionate and innovative support program which affirms the value of the medical family. The program provides the spouses of physicians the opportunity to understand and adapt to the stresses inherent in the medical family, and to achieve a higher level of satisfaction in their personal lives.

Missouri's De Novo program began in 1995 by offering free-of-charge group support meetings to the spouses of physicians impaired by chemical dependence, mental health difficulties, and/or physical impairment. De Novo is now expanding to include the spouses of all Missouri physicians. Spouses meet monthly in group sessions. Each two-hour session is run by a professional facilitator, trained in group therapy, and offers a safe, secure, confidential forum for physician spouses to express their frustrations and concerns. Each facilitator is ready and willing to make appropriate referrals for medication management and for children in distress, and can provide information about valuable community resources. Five separate group meetings are held for spouses living in the areas of St. Louis, Kansas City, Cape Girardeau/Poplar Bluff, Springfield, and Jefferson City/Columbia/northern Missouri.

The De Novo program was conceived and implemented by Robert Bondurant, RN, LCSW, coordinator for the Missouri Physicians' Health Program (MPHP). The MPHP exists to assist physicians who are impaired by alcoholism, drug dependence, psychiatric problems, and/or physical impairment. The MPHP's mission is to provide these impaired physicians with the help they need to recover and become healthy, productive professionals.

In helping scores of impaired physicians, Bondurant and members of the Missouri State Medical Association, which sponsors the MPHP, recognized a need to reach out to the spouses of impaired physicians. "These spouses are under tremendous emotional stress," says Bondurant. "It is often compounded by heavy financial burdens, and they deserve special attention, not only for their own well-being but also to aid in the recovery of the impaired physicians."

In order to benefit from the experience of others, Bondurant researched impaired-physician spouse support programs nationwide. To his surprise, only Texas, Florida, and Oklahoma offered programs utilizing group therapy. He learned that most of the groups were run by dedicated, though relatively untrained, community or medical Alliance volunteers. Relying on his own experience with impaired physicians, Bondurant decided to model his spouse support program on the philosophy of Alanon and on the organizational structure of MPHP. He proposed that each of Missouri's five regional Physicians' Health Programs for impaired physicians include a professional group facilitator, such as a psychiatrist, a clinical psychologist or a licensed marriage and family therapist, to run a spouse support group. He hand-picked five regional group facilitators, explained his plan, and with the blessing of the Missouri State Medical Association, the MSMA Alliance, and a modest budget of only $3,000, the De Novo program came to life.

De Novo's success sparked interest in expanding the program to include the spouses of all physicians in Missouri. To that end, a task force convened in June 1997 to discuss the details. Task force members, including Bondurant and the spouses of physicians from a variety of specialties representing a number of county Alliances, continue to meet every six weeks to to evaluate De Novo's progress, oversee fund-raising efforts, and to discuss how best to spread the word about the De Novo program throughout Missouri's medical schools and medical communities.

Task force members also recognize an ongoing need to explore the special stresses associated with the medical marriage in order to best tailor De Novo to those who seek support. According to Dr. Roy Menninger and Dr. Glen Gabbard, in their book, *Medical Marriages,* physicians can suffer from a number of external and internal stressors which can

Continued on page 650

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affect the medical marriage. External stressors can include:

- ✔ long work hours which leave little time for spouse and family;
- ✔ emotional strain caused by the disparity between the limitations of medicine and society's demands for perfection;
- ✔ pressures to keep abreast of the latest developments in medicine;
- ✔ changes in patterns of practice, including the increased stresses associated with group practices, managed care, changes in levels of reimbursement, extra paperwork, etc.;
- ✔ threat and reality of malpractice suits.

In addition to these external stressors, the personality profile of many physicians predisposes them to a number of internal stressors. These can include:

- ✔ need to control others and the surrounding environment;
- ✔ restricted ability/desire to express emotions, warmth, and tenderness;
- ✔ need for respect from colleagues, patients, and the community takes precedence over needs of family;
- ✔ dogged pursuit of mastery and perfection;
- ✔ public confidence but private self-doubt and fragile self-esteem;
- ✔ excessive devotion to work and productivity to the exclusion of pleasure and interpersonal relationships;
- ✔ lack of ability/desire to enjoy unstructured time;
- ✔ concerns about own physical well-being with tendency toward having recurrent migraine headaches, back aches, etc.

These stressors can make living with a physician a challenge and forging a healthy, happy relationship a real accomplishment. According to psychologist, Mary Flanagan, PhD, De Novo facilitator in Columbia, many physician spouses suffer from the "princess phenomenon." They have high status in the community and material well being, but despite these advantages, they feel emotionally isolated. Often, they don't feel comfortable complaining about their spouse or marital difficulties for fear of being misunderstood or damaging their spouse's reputation. Many suffer in silence. Some act out their distress through the overuse of alcohol and/or drugs, overspending, shoplifting, overeating, infidelity, etc. A few even take their own lives.

The De Novo program hopes to offer physician spouses who are in distress an opportunity to heal. Through the group sharing experience, and the expertise of the facilitators, De Novo participants can unburden themselves in a confidential, secure environment, surrounded by individuals who are experiencing similar stresses and who understand what it is like to be a partner in a medical marriage. Over time, the new insights gained, the new understandings forged, the new relationships built, the new strength gained, together, can lead to a new approach to life and new hope for a healthier future. The time for De Novo is now. Lets's spread the word. MoMed

If you would like more information
about De Novo, contact:
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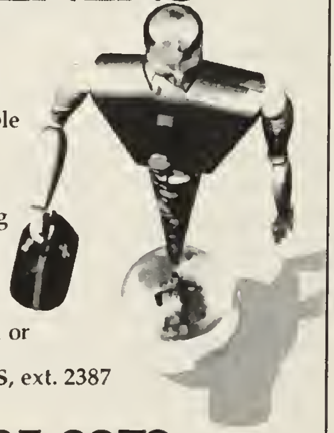

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Data, Information, and Knowledge: What Do You Have?

Eugene R. Worth, MD, MEd

Medical informatics is a relatively new specialty for physicians. Very simply stated, medical informatics is concerned with computing applications in medicine. However, that would greatly understate its impact for all physicians. The underlying goal of informatics is to manage complex information resources, regardless of the mechanism of data storage.

Let's look at a three-tier approach to our understanding of knowledge. We need to deal with the following terms: *data, information,* and *knowledge.* The numbers 34.5, 11.5, and 10,000 are meaningless when taken out of context, and if told that these numbers have something to do with patient care, they become little more than *data.* However, when one knows that a patient has a hematocrit of 34.5%, 11.5 grams of hemoglobin, and a white cell count of 10,000, the numbers transcend the realm of data and provide useful *information.* Is this information complete? Not yet.

In a specific setting, this information might be normal or abnormal. What if this hemogram came from a 26-year-old female who is eight weeks pregnant, whose prior hemoglobin was 14.5 grams, and who is presenting to the emergency department with acute abdominal pain? *Data* becomes *information* which, when applied at the moment of need, becomes *knowledge.*

> ***Data* is good, *information* is better, but *knowledge* is empowering**

In the same manner, a physician's practice consists of a number of insured lives (data). When the physician knows that 15% of those lives are insulin-dependent diabetics, 25% are hypertensive, and 35% are obese, then information can be applied to positively manage that physician's practice. Now, if any one of these patients comes to the office and a reminder were generated for the physician about services or follow-up checks needed on that visit, information becomes knowledge. *Data* is good, *information* is better, but *knowledge* is empowering.

This morning, I took my car to the dealer for service. I mentioned a recurring problem, but I couldn't remember when it first occurred. Working with admittedly antiquated technology, it took the service manager less than a minute to pinpoint the date, number of miles on the car, symptoms, and repairs performed. Are Missouri physicians armed with the same abilities to recall patient symptoms several years and thousands of miles later? With few exceptions, I think not. In fact, I doubt that many physicians could accurately state the numbers of patients with chronic diseases in their practice, and probably cannot document that the physician's care meets HEDIS indicators or follows AHCPR guidelines.

Insurance companies and managed care organizations control better information about your practice than you do. Until Missouri physicians become proactive, track patient indicators in their practices, and pool this data into a larger repository, insurers will have their way with physicians. Knowledge of your patient population, delivery of care, and cost of that delivered care makes all the difference when negotiating reimbursement rates with insurers and managed care companies.

It is time for Missouri physicians to adopt new technology, new management techniques, and new information resources. Knowledge results when information and data are appropriately applied at the point of need. MoMed

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Physician Income

Source: AMA Physician Marketplace Statistics 1996

	Per Nonfederal Physician					
	in thousands of dollars, 1995		percentages, 1996			
	A	B	C	D	E	F
All Physicians	$195.5	$13.7	27%	12%	43%	18%
Specialty						
General/Family Practice	131.2	7.8	23%	13%	41%	23%
Internal Medicine	185.7	13.1	40%	9%	38%	13%
•General Internal Medicine	159.5	11.5	39%	10%	37%	14%
•Cardiovascular Diseases	292.3	17.5	47%	9%	34%	10%
•Gastroenterology	256.5	18.9	38%	6%	43%	13%
•Other	196.7	15.2	37%	6%	44%	13%
Surgery	269.4	18.5	35%	8%	43%	14%
•General Surgery	244.4	16.9	39%	10%	41%	10%
•Otolaryngology	232.3	14.2	22%	9%	56%	13%
•Orthopedic Surgery	332.2	19.4	23%	8%	53%	16%
•Ophthalmology	240.8	22.5	47%	7%	29%	17%
•Urological Surgery	243.4	18.4	48%	6%	38%	8%
•Other	325.2	17.3	24%	6%	49%	21%
Pediatrics	140.5	9.0	1%	24%	49%	26%
Obstetrics/Gynecology	244.3	15.0	9%	18%	58%	15%
Radiology	244.4	18.5	34%	11%	40%	15%
•Diagnostic Radiology	245.2	20.5	31%	11%	39%	19%
•Other Radiology	243.3	15.8	38%	11%	41%	10%
Psychiatry	137.2	10.4	13%	12%	36%	39%
Anesthesiology	215.1	19.0	28%	13%	46%	13%
Pathology	209.4	16.7	30%	11%	42%	17%
Other Specialty	188.5	13.6	27%	10%	46%	17%
•Emergency Medicine	184.4	14.5	23%	16%	45%	16%
•Neurology	197.8	12.7	26%	13%	47%	14%
•Dermatology	214.9	14.0	33%	4%	46%	17%
•Other	170.3	12.2	27%	6%	47%	20%

A: Average Net Income after Expenses before Taxes
B: Average Deferred Compensation
C: Average Percentage of Revenue from Medicare
D: Average Percentage of Revenue from Medicaid
E: Average Percentage of Revenue from Private Insurance
F: Average Percentage of Revenue from Patients

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Resisting the Will to Deny

Kenneth K. Vuylsteke

> ***Responsible men never shirk responsibility, and so, when they must reject it, they deny it. They draw the curtain. They detach themselves altogether from the consideration of the evil they ought to, but cannot, contend with. Their denial compels their detachment.***[1]

On a recent Monday 52-year-old Frank Trustyew saw his cardiologist, Dr. Koehr, for chest discomfort. After a thorough examination, Dr. Koehr felt Mr. Trustyew had atypical chest pain and based on his extensive clinical experience, believed he needed a thallium stress test. Dr. Koehr's office staff called the patient's HMO for permission to perform the approximately $1,500 diagnostic test. They received a return phone call from the HMO's utilization review department and were told that the thallium test was not medically necessary and therefore coverage was denied.

Dr. Koehr's contract with the HMO states that he cannot disparage the HMO in any way to enrollees. He decides to inform his patient of the specific need for the test, and further, agrees to write a letter to the HMO detailing why it is medically necessary to protect the patient's health. On Friday, while the appeal is still pending with the HMO, Mr. Trustyew suffers a myocardial infarction resulting in congestive heart failure and death.

Two months later Dr. Koehr and the HMO receive a letter from the attorney for Mr. Trustyew's widow stating that she is filing a lawsuit against both the HMO and Dr. Koehr. The appeal letter from Dr. Koehr is attached. Dr. Koehr receives a 60 day notification letter from the HMO terminating his cardiological services. In addition, the HMO states it will not be liable for any malpractice since it was only making a utilization review decision and not practicing medicine. What can Dr. Koehr do?

Missouri House Bill 335[2] (HB 335) contains an anti-gag clause" provision prohibiting HMOs or any other entity from restricting treatment option information to patients.[3] The new law also states "a health carrier shall not terminate a contract with a health care professional unless the health carrier provides the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for review or hearing . . ."[4] In addition, Dr. Koehr may request a hearing within 30 days before a hearing panel comprised of at least three persons appointed by the health carrier. At least one person on that panel must be a clinical peer of Dr. Koehr with the same or similar specialty. He is then entitled to a decision from the hearing panel within 15 days after his hearing.[5]

If the HMO's hearing panel upholds Dr. Koehr's termination, he still may bring an action for wrongful discharge in a Missouri court. As grounds for his lawsuit against the HMO, the doctor should include an allegation that "no health carrier shall terminate a contract or employment solely or in part because a health care provider in good faith: advocates on behalf of an enrollee . . . or appeals a decision of the health carrier."[6] The new Missouri statute reduces the burden imposed on the discharged doctor in that he need only show that the HMO terminated his employment **in part** because he exercised his advocacy role on behalf of his patient.[7]

Indeed, if the doctor had told Mr. Trustyew of his right to an expedited review of the HMO's denial of his thallium stress test, Dr. Koehr would be in a better position to avoid a successful malpractice claim against him. Under the new law, "a health carrier shall notify an enrollee orally within seventy-two hours after receiving a request for an expedited review of the carrier's determination, and shall provide written confirmation of its decision covering the expedited review within three working days of

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providing notification of the determination."[8] An expedited grievance is proper where a health carrier's decision "would seriously jeopardize the life or health of an enrollee or would jeopardize the enrollee's ability to regain maximum function."[9]

HB 335 directs the Department of Insurance to employ an "independent review organization" (IRO) for the review of patient grievances. The resolution of such a grievance by the IRO shall be considered a final agency decision within the director's discretion, binding on the enrollee and health carrier, but subject to judicial review.[10] The "review panel" will consist of one physician[11] and his decision will become part of the final record for judicial review.[12]

In addition to sending a letter to the HMO, the doctor could have sent a letter to the Department of Insurance detailing the reasons why the thallium stress test was medically necessary. The HMO is prevented from retaliating against the physician for such advocacy since Missouri law now states "a health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that may jeopardize patient health or welfare."[13] The doctor would also buttress his claim for wrongful termination, should the need arise, since the law also states that "no health carrier shall terminate a contract or employment solely or in part because the health care provider in good faith provides information or files a report with the Department of Insurance."[14]

In particular, the new law seeks to support the physician in his traditional role as an advocate on behalf of his patient

Certainly, these new statutory provisions will make health carriers think twice before they terminate the employment of, or refuse to renew provider contracts with physicians who have actively advocated on behalf of their patients. Besides the ability to sue for lost income in the past and future, a physician may also be able to sue for punitive damages. Under Missouri law, in civil cases involving quasi-criminal wrongdoing by a defendant, punitive damages are awarded if supported by "clear and convincing evidence."[15] Arguably, the violation of the provisions of HB 335 relating to retaliatory discharge for reporting "practices by a health carrier that jeopardize patient health or welfare" is quasi-criminal conduct.[16]

The HMO's assertion that its utilization review denial is not a basis for a malpractice claim is undermined by House Bill 335. This statute specifically deleted a section of prior Missouri law providing that health maintenance organizations were not deemed to be practicing medicine.[17] Accordingly, adverse utilization review decisions may now trigger a cause of action directly against a HMO.

It is obvious that the Missouri legislature intended to create statutory protection for the doctor-patient relationship. In particular, the new law seeks to support the physician in his traditional role as an advocate on behalf of his patient. Unfortunately, by ratcheting down the compensation of doctors and by micro-managing their medical decisions through pre-certification and other utilization review measures, managed care organizations have placed a serious strain on the traditional fiduciary duty of the doctor to protect the best interest of his patient. Indeed, some would argue that capitation and other financial incentives for physicians create an atmosphere where a doctor acts more like an insurance company than a physician.[18]

By shifting the financial risk of treating patients in whole or in part onto the doctor's shoulders and by dispensing utilization review decisions that are contrary to the doctor's clinical judgments, managed care organizations seek to impose their will to deny medically necessary treatments for financial gain. By setting global incentives for utilization review employees regarding targets in the reduction of "medical-loss ratio"[19] and hospital days per 1,000 patients, they strive to create an environment for the will to deny to flourish. Sadly, a health care system that promotes the denial of care and pressures physicians to abandon their fiduciary relationship with their patients is not unprecedented.[20]

However, if physicians avail themselves of the provisions and protections of HB 335 and are willing to cooperate with attorneys for patients who have been denied medically necessary services, they may find not only job security but also by standing shoulder to shoulder with the legal profession, they can prevent the ultimate triumph of the will to deny. MoMed

The Author

Kenneth K. Vuylsteke is an attorney who serves as the chairman of the Medical-Legal Committee for the Bar Association of Metropolitan St. Louis. In addition, he is the legislative liaison for the Missouri Association of Trial Attorneys for HMO and health law matters. Recently, he served on the utilization review, grievances, and physician incentive task forces formed by the Missouri Department of Insurance to suggest regulatory language pursuant to the recently passed House Bill 335.

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Diagnostic Strategies for Pulmonary Arteriovenous Fistula in Pregnancy

Sunny Desai, MD; Robert Wright, MD; Sameena Malhan, MD
Deaconess Hospital, St. Louis, Mo.

ABSTRACT

Pulmonary arteriovenous malformations (PAVMs) are a documented cause of hemoptysis, and usually necessitate pulmonary angiography for a definitive diagnosis. However, the diagnosis can become more problematic in pregnancy. We recently saw a young woman in her fifth month of pregnancy with hemoptysis, who was found to have multiple PAVMs. We report this case to highlight the various non-invasive methods of making this diagnosis.

CASE REPORT

A 26-year-old G3A1P1 black female presented at 20 weeks gestation with a 10 day history of hemoptysis, headache, and lethargy. She did not have fever or purulent sputum but gave a history of nocturnal cough which was productive of a large amount of blood.

Her medical history was remarkable for a right lower lobectomy at the age of five for a pulmonary arteriovenous malformation, and her family history was significant for recurrent epistaxis in her father.

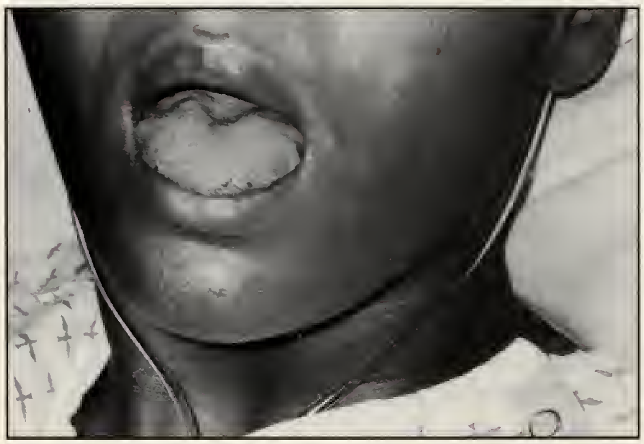

Figure 1. Note telangiectasias on tip of tongue.

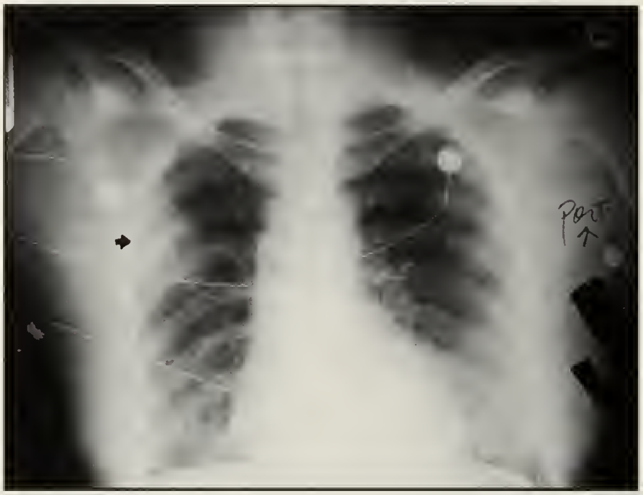

Figure 2. Chest x-ray demonstrates wedge shaped infiltrate at right upper lobe (arrow).

The patient was drowsy on admission but no focal neurological deficits were noted. Her vital signs were stable. There were a few telangiectasias noted on her buccal mucosa and tip of her tongue (Figure 1). Clubbing and cyanosis were absent. Further examination was significant for a right-sided surgical thoracotomy scar, gravid uterus and a soft systolic murmur. Chest radiograph (Figure 2) and CT scan (Figure 3) revealed an infiltrate in the right upper lobe.

Differential diagnoses of pulmonary embolism and hereditary hemorrhagic telangiectasia (Osler-Weber-Rendu Disease) with pulmonary arteriovenous malformations were entertained.[1-3] Pulmonary angiography would have been the gold standard, but concern about fetal radiation exposure led to non-invasive, low risk diagnostic procedures.[4,5] A ventilation-perfusion scan with reduced amount of perfusing particles (macro aggregated albumin) and a reduced radio-nuclide dose revealed a non segmental V/Q mismatch in the RUL corresponding to the

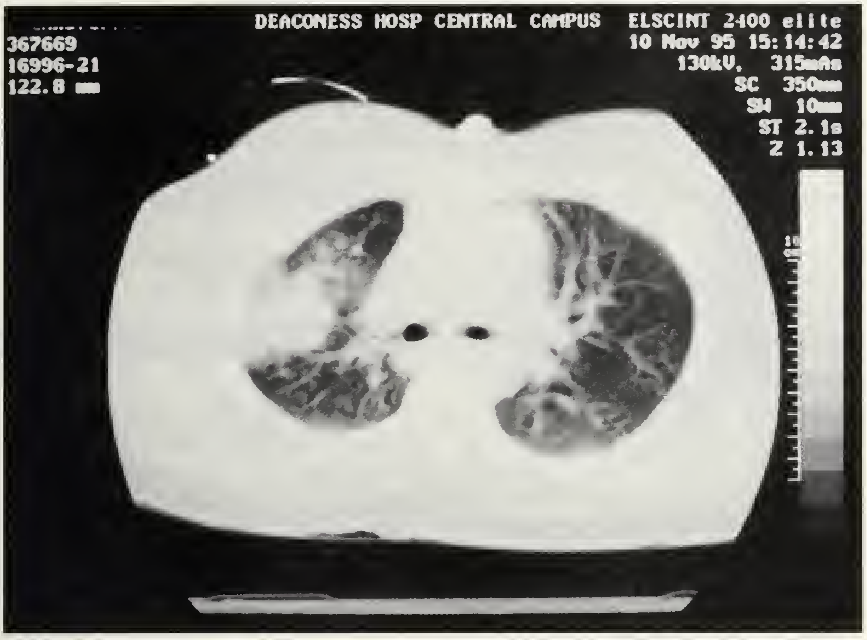

Figure 3. Computerized Tomograph without contrast (lung window), taken after 24 hours confirms the x-ray findings of the right-sided infiltrate.

pulmonary infiltrate, and immediate activity seen within the brain and kidneys on perfusion imaging (Figure 4) indicated a right to left shunt.

Another non-invasive test which confirmed our diagnosis of a PAVM, was a two dimensional echocardiogram with bubble contrast which demonstrated the delayed appearance (after three to six cardiac cycles) of micro cavitations in the left atrium consistent with an extra-cardiac shunt.[4]

The patient was observed in the ICU, where she sustained two more episodes of scant hemoptysis. The remainder of her hospital course was uneventful. She was then transferred to a tertiary care center for definitive treatment. Eventually, pulmonary angiography undertaken there revealed multiple bilateral pulmonary arteriovenous malformations. Successful embolotherapy with steel coils[6] of the bleeding RUL fistula was carried out, with treatment of the others deferred until the completion of her pregnancy.

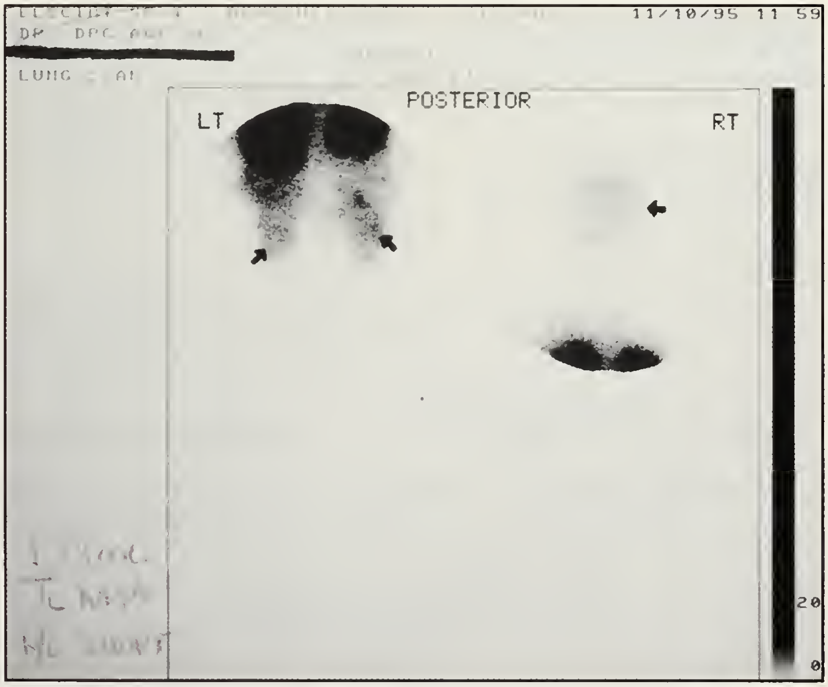

Figure 4. Perfusion images (two left arrows) demonstrate immediate uptake by the kidneys and (single right arrow) by the brain.

DISCUSSION

There are only a few cases reported on pregnancy associated PAVMs. Even though most are congenital, they usually are not detected until the 2nd or 3rd decades of life.[7,8] Increased vigilance is required on behalf of the primary physician, especially with the attendant life threatening complications which can occur viz.; hypoxia, massive hemoptysis, hemothorax, cerebrovascular accidents, and brain abscesses.[9] Moreover, pregnancy with its cardiovascular changes of increased blood volume and cardiac output coupled with the hormonally mediated vascular

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changes, is known to have an adverse effect on the vascular malformations.

The ventilation perfusion scan is a relatively safe means for determining a vascular shunt and also to exclude a pulmonary embolus in pregnancy. Since the brain and kidneys demand a significant portion of the cardiac output, immediate uptake of radio-nuclide is seen in these organs when a right to left shunt is present. A reduced amount of perfusing particles was used because normally these particles become trapped in the lung capillary bed during testing for a pulmonary embolus. However, since an AVM was suspected, administering the full dose would have resulted in systemic embolization of the macro aggregated albumin. Half the normal dose of radio-nuclide was also used to avoid unnecessary radiation exposure to the fetus. If desired further, the shunt can be quantified from the perfusion images.

The two dimensional echocardiogram afforded us an excellent sensitive and non-invasive test to confirm an extra cardiac shunt. Normally when agitated saline is injected into a peripheral vein, it does not reveal itself on the left side of the heart. However, if the shunt is at the level of the heart, the micro cavitations are immediately seen in the left atrium, and if at the pulmonary level, they are visualized after three to six cardiac cycles, as was evident in our patient.

Various other non-invasive methods to consider include, MRI of the vascular malformation[10] (investigational), and clinically assessing for orthodeoxyia, neither of which are very sensitive nor specific.

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1:30 pm	MSMA Reference Committees

Friday, April 17

8:30 -10:30 am	MSMA General Session
11:00-12:30 pm	Open Forum on AMA Issues
1:00 - 2:30 pm	General Session
4:00-6:00 pm	Second Session, MSMA House of Delegates

Saturday, April 18

10:00-12:00 noon	General Session
6:00-7:00 pm	MSMA Presidential Inauguration
7:00-8:30 pm	MSMA Reception

Sunday, April 19

7:30 am	Final Session, MSMA House of Delegates Breakfast Meeting

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Smoking-Attributable Mortality in Missouri, 1995

Nancy Miller, MEd, CHES; Eduardo J. Simoes, MD, MPH; Jian Chang, PhD

Background

Cigarette smoking is the chief preventable cause of premature death in the United States.[1] The U.S. Centers for Disease Control and Prevention (CDC) estimated that in 1988, the smoking-attributable mortality nationwide was 430,000 deaths.[2] Tobacco contributes substantially to deaths from cancer, cardiovascular disease, lung disease, low birth weight, sudden infant death syndrome, and burns.[3] Twenty-seven percent of Americans who die between the ages of 35 and 64 do so from tobacco-related diseases.[4] Overall, smoking causes more premature deaths than any other health risk behavior.[5]

The 1989 report of the Surgeon General, *Reducing the Health Consequences of Smoking: 25 Years of Progress,* classified 22 tobacco-related diseases as those causally linked to cigarette smoking, as determined by major epidemiologic studies.[6] These tobacco-related diseases include the following:

- neoplasms such as cancers of the lung, oral cavity, esophagus, pancreas, cervix, bladder, kidney and other sites;
- cardiovascular diseases such as hypertension, ischemic heart disease, atherosclerosis, stroke, aneurysm, and other arterial diseases;

Continued on page 662

Table 1. Smoking-Attributable Mortality by Cause of Death and Sex, Missouri, 1995

Cause of Death by ICD-9 Code	Male	Female	Total
Neoplasms			
Lip, Oral Cavity, Pharynx (140-149)	75	26	101
Esophagus (150)	131	28	159
Pancreas (157)	52	79	131
Larynx (161)	38	16	54
Trachea, Lung, Bronchus (162)	2,107	961	3,068
Cervix Uteri (180)	N/A	29	29
Urinary Bladder (188)	59	20	79
Kidney, Other Urinary (189)	81	9	90
Neoplasms Total	2,543	1,168	3,711
Cardiovascular Diseases			
Hypertension (401--404)	77	51	128
Ischemic Heart Disease (410-414)			
Persons aged 35--64	631	179	810
Persons aged 65+	989	701	1,690
Other Heart Dis. (390-398,415-417,420-429)	493	277	770
Cerebrovascular Disease (430-438)			
Persons aged 35--64	112	88	200
Persons aged 65+	262	98	360
Atherosclerosis (440)	67	46	113
Aortic Aneurysm (441)	135	31	166
Other Arterial Disease (442--448)	55	31	86
Cardiovascular Disease Total	2,821	1,502	4,323
Respiratory Diseases			
Pneumonia, Influenza (480-487)	298	228	526
Bronchitis, Emphysema (490-492)	191	113	304
Chronic Airways Obstruction (496)	910	618	1,528
Other Respiratory Diseases (10-12, 493)	13	12	25
Respiratory Disease Total	1,412	971	2,383
Perinatal Conditions			
Short Gestation / Low Birth Weight (765)	6	4	10
Respiratory Distress Syndrome (769)	1	1	2
Respiratory Conditions -Newborn (770)	2	2	4
Sudden Infant Death Syndrome (798)	4	3	7
Perinatal Conditions Total	13	10	23
Burn Deaths	1	1	2
Overall Total	**6,790**	**3,652**	**10,442**

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- respiratory diseases, such as pneumonia, bronchitis, emphysema, and other related diseases;
- perinatal conditions including low birth weight, respiratory distress, and sudden infant death syndrome; and smoking-related burn deaths.

The purpose of this article is to examine the toll of smoking-related deaths and years of potential life lost in Missouri during a one-year period – 1995.

Methods

Calculations were performed using the *Smoking-Attributable Mortality, Morbidity, and Economic Costs* software program (SAMMEC 3.0), designed by the CDC, to assist states in calculating the disease impact of cigarette smoking.[7] SAMMEC 3.0 estimates Smoking-Attributable Mortality and years of potential life lost by calculating the number of smoking-attributable deaths for 22 diseases among adults age 35 and older, four perinatal conditions for infants less than one year old, and burn deaths among all age groups (Table 1). Of course, not all deaths in the tobacco-related disease categories can be attributed to smoking. The probability of dying from one of these causes is called the risk, and the relative risk is the ratio of the risk of illness or death for exposed persons compared with those for non-exposed persons.

Smoking-attributable mortality for each tobacco-related cause of death, by gender and five-year age groups, was determined by multiplying the number of deaths by the population smoking-attributable risk. This figure, in an expanded formula to accommodate levels of smoking, is also referred to as the smoking-attributable fraction. The smoking-attributable fraction is a function of the prevalence of smoking and the relative risk of dying of a specific disease because of smoking.[8] The American Cancer Society's Cancer Prevention Study II estimated the relative risk for tobacco-related mortality in the U.S. by comparing the ratio of illnesses in exposed (current and former smokers) versus nonexposed (never smokers) populations (Appendix 1).[9]

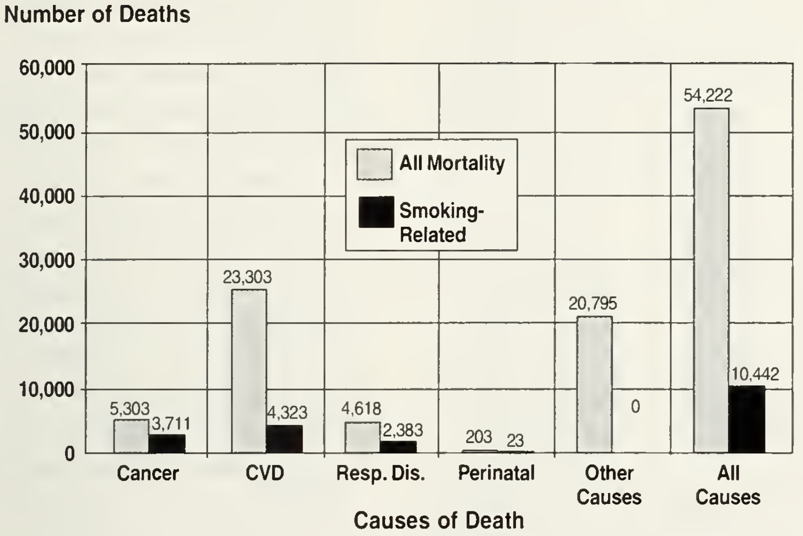
Appendix 1. Relative risk estimates attributable to smoking for current and former smokers (>35 years of age) compared with never smokers, by disease category and gender.

	Males		Females	
Cause of Death	Current Smoker	Former Smoker	Current Smoker	Former Smoker
Oral Cancer	27.5	8.8	5.6	2.9
Esophagus Cancer	7.6	5.8	10.3	3.2
Larynx Cancer	10.5	5.2	17.8	11.9
Lung Cancer	22.4	9.4	11.9	4.7
Bronchitis/Emphysema	9.6	88.8	10.5	7.0
COPD	9.7	8.8	10.5	7.0
Ischemic Heart Disease <65	2.8	1.8	3.0	1.4
Cerebrovascular Disease <65	3.7	1.4	4.8	1.4
Atherosclerosis	4.1	2.3	3.0	1.3

Missouri 1995 smoking prevalence rates were calculated by gender, age groups (35-64 and 65+), and smoking status (current and former smoking). The rate of maternal smoking during pregnancy was determined as well. These data were obtained from the Missouri Department of Health (MDOH) 1995 Behavioral Risk Factor Survey (BRFS) and from birth certificate data. Missouri mortality data for smoking-related causes by gender and 11 five-year age groups between age 35 to 85+, and perinatal deaths for persons under the age of one came from state birth and death records. Smoking-related burn deaths by sex and age groups were also obtained from state death records. Missouri population distributions by sex and five-year age groups were drawn from the 1990 U.S. Population Census. The smoking-attributable mortality rate was age standardized to the distribution of the U.S. population based on the 1980 Population Census, which is the SAMMEC software program default.

Smoking-attributable years of potential life lost were calculated by multiplying tobacco-related deaths by years of potential life lost. Smoking-attributable years of potential life lost is the sum of years of life lost for premature deaths for all causes of death related to smoking. It can be

Figure 1. Smoking-Related Mortality vs. All Mortality by Cause Missouri - 1995



measured in terms of life lost prior to a particular age, such as age 65, or to full life expectancy. For this study, we calculated years of potential life lost that accounts for life expectancy at age of death in the U.S. in 1991.

Results

Overall, in 1995, there were 54,222 total deaths from all causes in Missouri. Of those, 10,442 (19.3%) were attributable to smoking (Table 1). Nearly 30% of those deaths were due to lung cancer, with an additional 24% due to ischemic heart disease (Figure 1). Eleven percent of perinatal deaths were tobacco-related. Sixty-five percent of the smoking-attributable deaths were among males, and 26% were among Missourians less than 65 years old. The overall crude rate for smoking-attributable mortality was 429.4 per 100,000 population. It is estimated that 920,000 Missourians, or 24.3% of adults over age 18, were smokers during 1995.[10]

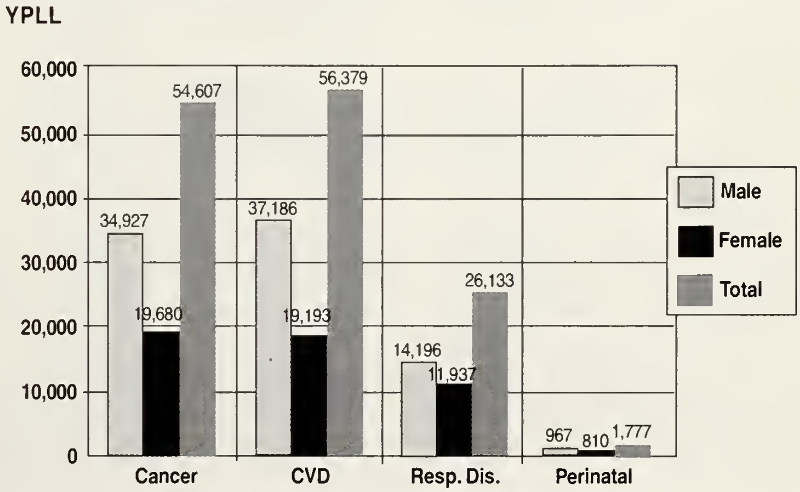
In 1995 alone, 138,951 smoking-attributable years of potential life lost were lost in Missouri, with 63% of these years lost among males (Figure 2). The causes of death were almost evenly split between cardiovascular diseases and various neoplasms. This means that of the 10,442 Missourians who died from smoking-related causes in 1995, each could have had their lives extended an average of 13.3 years if they had never smoked. The crude rate for years of potential life lost was 5,652.9 per 100,000 population.

Discussion

The findings of this study show that each day in Missouri, for a smoking-attributable mortality rate of 19.3%, smoking causes more than 28 deaths. More people died in Missouri during 1995 from smoking-related diseases than lived in counties such as Carroll (pop. 10,400), Lewis (pop. 10,200), or Grundy (pop. 10,400) during this year. This death toll is more than twice the annual total number of Missouri deaths from accidents, AIDS, homicide, and suicide combined. The MDOH

Continued on page 664

Figure 2. Smoking Attributable Years of Potential Life Lost (YPLL) by Disease Cause, Missouri - 1995



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first calculated smoking-attributable mortality in 1986, when it found that 15% of all deaths were smoking-related.[11] The rate of such deaths continue to increase due to higher smoking prevalence in past decades and the long latency period for smoking-related diseases to reach their climax. According to a study conducted by CDC, state-specific smoking-attributable mortality in 1990 ranged from a low 13.4% in Utah to a high 24.0% in Nevada.[12] Missouri ranked 39th highest at 20.2%, having 122,136 years of productive life lost. These figures, which are close to the estimated results, vary slightly from them as a result of the methodology used.

Smoking-attributable mortality will be a problem in Missouri for quite some time to come. In a study conducted by Hagdrup, Brownson, and Simoes, trend analysis of smoking rates among adult Missourians (age 18 and above) for the period 1986-1995 revealed that there has been no statistically significant decrease in smoking prevalence in the past decade.[13] According to the CDC, Missouri's 1996 smoking prevalence among adults (above age 18) has reached 27.7%, an increase from 24.3% in 1995.[14] These data by the CDC also show that Missouri's smoking prevalence exceeds those of most of our neighboring states and is greater than the nation as a whole at 22.4%. One of the national health objectives for the year 2000 is to reduce smoking among adults to no more than 15%.[15] The study by Hagdrup et al estimates that Missouri's rate of smoking will not reach 15% until the year 2040, if current trends continue. However, according to Hagdrup et al, the highest prevalence rate of current smoking among Missouri's adults is in the 18-34 age group (30.2%). More disturbing is the fact that the current smoking rate among Missouri's high school students is second highest in the nation at 39.8%.[16] These data indicate that Missouri's smoking prevalence, especially by individuals under the age of 35, may produce continued high rates of smoking-attributable morbidity and mortality--and associated economic costs--for years to come.

One might look to Missouri's sociodemographic characteristics to explain its high smoking rates and subsequent smoking-attributable mortality. However, Missouri's population does not differ greatly from that of the U.S. for age, race, education, or income, which are all factors related to smoking prevalence. Another explanation for Missouri's high tobacco consumption may be its tobacco excise tax (17 cents), which is the eighth lowest in the nation, far below the highest (Alaska at $1) and less than half the national average of 36.5 cents. Increasing the excise tax on cigarettes is one of the most cost-effective strategies to reduce tobacco consumption among adults and prevent youth initiation of tobacco use.[17] That effort can be further enhanced by using the increased excise tax funds to finance anti-smoking campaigns, as was done in California, Arizona and Massachusetts, and resulted in greater declines in tobacco consumption than among states in the rest of the nation.

Although the estimates of smoking's adverse impact are based on extensive epidemiologic research, there are a number of limitations to the methodology used in this study to estimate smoking-attributable deaths. First, the calculations were limited to infants less than one year old and persons 35 years of age and older, thus excluding deaths caused by smoking among those younger persons 1-34 years of age. Second, the calculations do not include mortality caused by cigar and pipe smoking, or smokeless tobacco use. Third, the smoking prevalence rates used were from 1995, whereas the smoking-attributable mortality that occurred that year resulted from higher smoking prevalences during the previous 30 years. Fourth, deaths due to exposure to environmental tobacco smoke were not considered. As a result, the estimates from this study are likely to be conservative. Finally, it is probable that misreporting would cause some age or sex specific mortality rates to be under or overestimated. However in 1994, SAMMEC II results (an earlier version of the program) were compared with physician reporting on death certificates in Oregon and found to have a 97% match, which provides support for the methodology used in this study.[18]

These findings underscore the tremendous health and economic burden caused by tobacco use. The results indicate that significantly more resources are needed to aggressively promote tobacco prevention and control activities statewide, as well as a need to increase the cost of tobacco products, strengthen laws to prevent sales of tobacco to minors, and protect individuals from environmental tobacco smoke, in order to significantly reduce the prevalence and resulting morbidity and mortality attributable to smoking. MoMed

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A Conversation with Ruth Kauffman, MD: 48 Years of Medicine in Missouri

Thomas D. Eppright, MD; Shane Bradley; Lori Moseley

Ruth Kauffman, M.D., has led a long and distinguished career meeting the health needs of Versailles, Missouri. Dr. Kauffman was born and raised in Versailles. She completed her pre-medical training (1944), and a Bachelor of Science in Medicine (1946) at the University of Missouri-Columbia. Dr. Kauffman completed her Doctor of Medicine at Washington University in St. Louis, in 1948. Her residency training was at St. Luke's Hospital in 1949, also in St. Louis. Dr. Kauffman has practiced family medicine in Versailles since 1949. Her partners in practice were Dr. A.J. Gunn at the beginning, and then for more than forty years Dr. A.J. Gunn's son Dr. Jack Gunn, and Dr. Ray Lyle. Even though she "retired" last year, Dr. Kauffman still provides medical care to several area nursing homes. Dr. Kauffman was Board Certified in Family Medicine for 15 years of her practice. Dr. Kauffman has been married to William G. Johnson, an attorney, for 47 years. She and her husband are the parents of five children and the grandparents of nine grandchildren.

Throughout her career Dr. Kauffman has been an inspiration to other physicians. As a preceptor for the University of Missouri-Columbia, she has been involved in the mentoring of more than thirty medical students. Dr. Kauffman is currently a member of the American Academy of Family Practice, American Medical Association, Missouri State Medical Association, and Lake Ozark Medical Society. She served on the Council of the Missouri State Medical Association for several years, as President of the Lake Ozark Medical Society for two years, and is currently on the University of Missouri Alumni Board of Governors.

Dr. Kauffman recently spoke to us about her life and her practice of medicine. Personally, Ruth Kauffman is soft-spoken, articulate, and unassuming. During our interview she spoke with great thoughtfulness and sincerity. Dr. Kauffman seemed genuinely surprised that we considered the interview not only a privilege, but a privilege worth sharing with the readers of *Missouri Medicine*. Our interviewer was Lori Moseley, a fourth year medical student at the University of Missouri-Columbia.

LM: **Today, we are here with Dr. Ruth Kauffman, a family practitioner from Versailles, Missouri. Would you tell me about your decision to become a physician?**

Kauffman: When I was in the 5th grade my mother had inflammatory rheumatism; her brother was a family doctor in a small town in Kansas. He took my mother and I there for her physical therapy, and I adored him. He was so good to my mother and I saw how everyone in that town adored him. I'm sure that is where the seed of my interest in becoming a doctor came from. In high school at Versailles, when we were getting ready to go to college, I had interviews with the representatives from the schools and they would say, "You don't want to do that [become a doctor]." And the more they said that the more I thought about it. During high school I had generally been discouraged from becoming a doctor. But when I left high school our superintendent called me into his office and he said, "Ruthie, you can do anything you want to do." And that really spurred me on. I have thought about that often.

LM: **How did your family feel about your decision? Were they against your decision?**

Kauffman: No, my mother said, "Girls can do anything boys can do." No, I was never discouraged, but my dad always said, "Where is the money coming from?" I worried about that till the day I graduated from medical school. I was one of only five girls in my program at the University of Missouri. One didn't last very long. One girl had panic disorder and she quit after awhile. One girl transferred to Northwestern, so there were just two of us that graduated. There were 40 in our class and only 20 graduated, so there was a lot of weeding out. I only had one professor in those two years that didn't really like women. He made us four girls work together in our physiology lab.

LM: **Do you feel that there were any other instances in your medical education where you were treated differently?**

Kauffman: No, not significantly. I transferred to Washington University after two years at MU and the professors there were wonderful. They were Nobel Prize winners, researchers, and superb clinicians; they were aristocratic, wonderful men. I think I had such an adoration for them that they liked me. I had really good years down there. When time came to make up my mind about what I wanted to do I decided to get a rotating internship; I wanted to see something of the world. I applied to internships in New York and Honolulu. But my advisor said, "Ruthie, you don't want to do that. Go over to St. Luke's where the same professors treat their private patients, and you will get the best education possible." I took his advice. I was one of the first women they ever had at St. Luke's, so I was under the watchful eye of the staff. There had been one woman intern ten years earlier. Anyway, I was put in a nurses' dorm.

LM: **Did the male interns have similar rules?**

Kauffman: The male interns had their own house, no rules. But we had a 36-hour day and 12 hours off, so I didn't want to do anything but go to bed. The male interns were very good to me. We shared our anxieties. I think I probably got the best education there that I could have gotten anywhere in one year. We had excellent obstetrics training. We had to watch every patient from admission to 10 days after delivery.

LM: **At that time you knew you wanted to go into general practice with obstetrics?**

Kauffman: I was getting to that. When I was at Washington University on clinical rotations, every time I was on a rotation, that was what I wanted to be. Money was playing a part too. As an intern I was making $25 a month. By that time I owed $1500. That was like a noose around my neck. My dad always thought it was a disgrace to owe anybody. So between my junior and senior year I went back to Versailles and worked in Dr. A.J. Gunn's clinic. He suggested that I come back to Versailles and practice with him. I thought that would be a good way to get started. I truly respected his wisdom and family practice expertise, especially in obstetrics, emergency medicine, and orthopedics. I learned a lot from him.

LM: **While your husband was in law school and you were a new physician, you had two babies. How did that effect your life?**

Kauffman: It was pretty stressful. When I had my first baby I went back to work after one week, and I felt like a wet noodle. I'll never forget when I was leaving work my first day back, breathing a sigh of relief, and the phone rang. This lady said, "I just have to have you come see me, just 10 miles out of town." I turned to Dr. A.J. Gunn and said, "I can't do that. I can't drive out there." He said, "Oh, we'll get someone to drive you." So I went. After that I gave fair warning when I was going to have a baby that I was going to take a month off.

LM: **How did the three of you (Dr. Jack Gunn, Dr. Ray Lyle, and yourself) manage to practice together for more than forty years?**

Kauffman: Many doctors have asked us that. It wasn't any problem. Dr. [Ray] Lyle was a soft-spoken and gentlemanly person that people instantly liked. Dr. [Jack] Gunn was more like his father - a

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physician with a strong personality, but totally dedicated to medicine. He was a terrific orthopedist. We depended on each other for call, and to look after each other's families. We delivered each other's babies. We were best friends. And of course our spouses were compatible as well.

***LM:* Do you feel you had any trouble getting patients because you were a woman?**

Kauffman: No, I don't think I had any trouble, partly because my family was well known in town. Everyone knew I went to medical school. Dr. A.J. Gunn would go into the waiting room and tell patients, "You ought to see Ruthie, she knows all about the newest treatments." He would tell them how smart I was, and what a good education I had. So I owe a lot to him. He died a few years later, however.

***LM:* Did you treat teachers you had in grade school or high school?**

Kauffman: Yes, it was truly a general practice. But delivering babies was the most exciting thing I ever did. I would work myself up into a sweat, but then when the baby arrived everybody was so happy. Not that we didn't have troubles. One morning someone who was coming in said she was going to have a baby that day. I told her to meet me at the clinic. And five minutes later she called back and told me she had already delivered the baby on the front porch. So I ran out there with the OB nurse and the equipment, and here was this lady and her baby lying in bed; the mother had a fourth degree perineal tear. I was seven months pregnant and I repaired the tear in about an hour with good results.

***LM:* The reason you stopped performing obstetrics was because of other hospitals in other larger communities?**

Kauffman: Insurance was coming along at about that time. Blue Cross was the one everyone was acquiring and they wouldn't pay us, because we didn't have an operating room available; it was never a financial success. We charged $75 for delivery and $10 a day for room and board. Patients sent out to a restaurant for food, and we paid for that. And of course some didn't pay anything. We charged $2-$3 for office calls until Medicare, then we raised it to $5.

***LM:* Tell me a little bit about what practicing medicine was like when you first started.**

Kauffman: When I was thinking about that for this interview I called my partners and said, "Do you remember when we checked our bags everyday to make sure we had plenty of medicine in our bag?" We were a walking pharmacy. Every day you would make a house call or two or three or four, in different directions. None of the little towns around had any doctors or pharmacies, and everyone thought that if you were sick at all you shouldn't get out of the house. The doctor should come to see you, especially if it was in the middle of the night. So we had this bag in which we carried every kind of emergency injection that was available at the time- adrenaline, diuretics, digitalis, etc. Nobody thought they should go to the hospital. I can't tell you how many house calls I made for congestive heart failure. One of them really made my reputation early in my practice in Versailles. It was an older lady sitting under a shade tree blowing bloody froth from her mouth; she was gasping for air. I had an oxygen tank in my car, and I gave her some IV morphine, IV aminophylline, and a diuretic. In fifteen minutes she was dry as a bone. She had that happen to her a couple of times after that; she wouldn't take her medication regularly. We *never* considered sending a heart patient to the hospital. We treated an acute MI with absolute and total bed rest. I would have to visit them twice a day for at least a week. They stayed in bed a month. I can't tell you how many times I treated acute MI patients at home with good results. Another difference is the purity of medications. Digitalis at that time was very unrefined. Patients could never overdose because they would get sick and vomit. As it was refined, drug toxicity became more common. Asthma was a common house call emergency. Phenobarbital was the standby for many ailments, such as anxiety, hot flashes, and others. Phenobarbital was the only medication we had for hypertension. We had nothing to truly control blood pressure. When thiazides came out eight or nine years later that was wonderful, something that finally worked.

***LM:* When new treatments came out, were you reluctant at first or did you jump on the band wagon?**

Kauffman: I was the reluctant one. Dr. [Jack] Gunn was the one who jumped on the band wagon. He was the first one that treated a patient with a thiazide. It was barely off the press. Medications today are so wonderful. Another medication that changed the face of family practice was vaccines. We had 10 cases of polio in the summer of 1952, and Dr. [Jack] Gunn and I worked around the clock. Dr. [Jack] Gunn eventually caught polio himself. It was wonderful when the polio vaccine became available. Penicillin, of course, made a huge impact on my practice. Penicillin was very expensive, so you had to know someone really needed it before you gave it. But to be able to cure acute otitis in children was wonderful.

LM: How did you continue learning about all the new treatments and diagnoses?

Kauffman: Well, the three of us talked a lot. Any time we had a patient we thought we didn't know enough about we put our heads together. Every year we attended meetings like the Southwest Clinical Society in Kansas City, the Missouri State meetings, etc. We read the primary journals, especially the journal of the American Academy of Family Physicians. I still make sure I read that one. Studying for the board exams was also very helpful.

***LM:* How are you currently involved in practicing medicine?**

Kauffman: Well, I retired officially last year but I have about 50 patients in nursing homes. I am the Medical Director of one nursing home. Besides that, psychiatry has always intrigued me, so when I retired I started volunteering with a psychiatrist in the Morgan County Counseling Center. He sees the patients when they are acutely ill and I assist with medical follow-up. It helps him to see more patients, and I have enjoyed learning more about psychiatry.

***LM:* Tell me more about aspects of medicine today that you don't like, or what you think has caused an increasingly negative impression of medicine in our society.**

Kauffman: I don't really like the political side of medicine. I don't know exactly what has caused the current climate in our culture regarding medicine. I think greed has played a part. Before Blue Cross ever came into existence, if I sent an elderly farmer to have a cancer removed, the surgery could cost him his farm. I felt we would regret the day that physicians charged like that. Had there been more empathy for the poor I don't think medical inflation would have gotten so significant. Once insurance started, physicians decided they would charge even a little more. It has mushroomed. Now the cost for anything is ridiculous. I had a broken leg last year and my bill was $30,000. Forty years ago it might have been $150. I know when I had my first baby one week at the hospital cost $65.

***LM:* Did you run into any trouble being reimbursed, working in a rural community?**

Kauffman: Yes, Morgan County is a poor county. This was especially true before tourism developed at the Lake. I was always glad when patients were on Medicaid. I welcomed it. I was glad they could get the office calls and antibiotics they needed. It did concern me when I made nursing home visits and got a dollar and a half for a visit. That has greatly improved.

***LM:* Are there any other changes that you would like to talk about?**

Kauffman: When I started practicing medicine the only advice I could give on contraception was abstinence, diaphragm fitting, and condoms. I developed a practice with young women requesting contraception, and later, pap smears. And I was the physician of a lot of those same womens' children. I remember the year birth control pills became available. That was wonderful, and exciting. Here women could actually plan their family instead of planning to have a family. Another major difference is the preponderance of testing done today. In my first office we gave everyone a VDRL (we frequently got positive results). We tested urinalysis and blood sugars routinely, but nothing else. BMRs were the only tests we had for thyroid deficiency, and they didn't work

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too well. That is one thing that has done wonders for medical practice. Of course, I think they can be overdone. Many tests aren't necessary if you take a thorough physical and history. When I was in medical school if you ordered a test and you didn't have three good reasons for it, you were downgraded.

LM: **I've heard a lot about your wonderful bedside manner and I would like to know if you could teach us or future generations of medical students and physicians how we could emulate that.**

Kauffman: I appreciate you saying that. I didn't know I had such a wonderful bedside manner. Those wonderful professors I had back in medical school stressed that it is important to be interested in the patient and the patient's disease. It is important to put yourself in their situation, and treat them with respect. I like people. You shouldn't go to medical school if you don't like people. You shouldn't become a doctor only for the financial gain. You need to get your satisfaction from seeing people get well. I am interested in the patient, the patient's family, as well as the patient's illness. An aspect of good bedside manner is giving your time. You know that the patient has confidence in you when they come to you and ask what they should do about their teenage daughter's troubles. They are not going to go to a doctor they feel is hurrying them. I didn't realize I was practicing psychiatry but I would spend a half hour with a depressed patient who was overburdened. That was therapy. I don't think there is a secret to having good bedside manner. I think having a personality that involves caring about people is crucial.

LM: **It was very nice talking to you. This has been a real privilege.**

Kauffman: I've really enjoyed talking to you. MoMed

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Emergency Medicine Quiz #2

Mark T. Steele, MD
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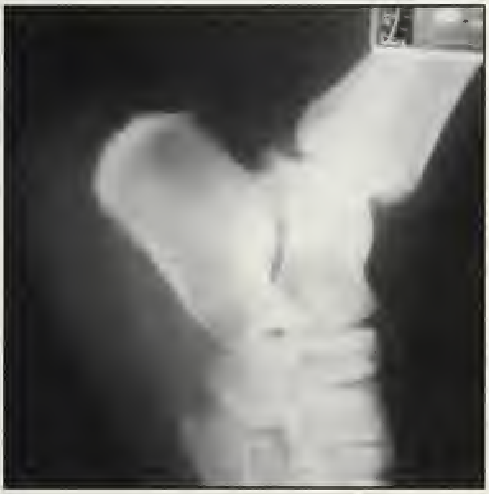

Figure 1

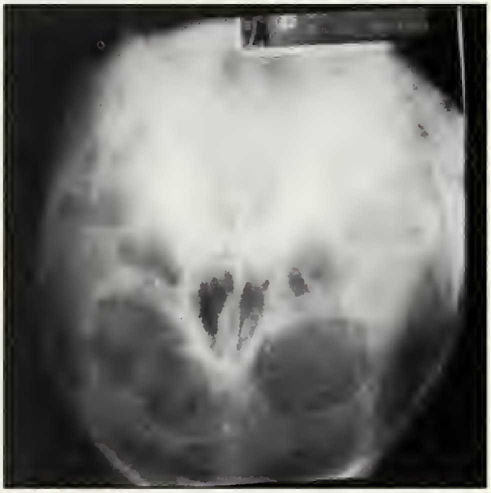

Figure 2

Case 1 - A 37-year-old female was walking barefoot and states that she stepped on some broken glass and cut her foot. The patient presents to the emergency department complaining of a cut over her heel. On physical examination the patient has a two centimeter laceration on the bottom of her heel. The patient has a positive foreign body sensation. An x-ray was obtained (Figure 1).

Case 2 - A 27-year-old male presents to the emergency department following a motor vehicle accident. The patient was not immobilized and hit the windshield with his head. There was no loss of consciousness. The patient suffered multiple lacerations to the face and forehead. The largest laceration is over the right eyebrow and is three centimeters in length. Upon wound exploration, a grating sound is heard when the eyebrow wound is probed with a curved hemostat. An x-ray was obtained (Figure 2).

1. Whether or not glass will visualize on convential x-ray depends on which of the following?

a. Source of the glass
b. Whether or not the glass is leaded
c. Whether or not the glass is pigmented
d. None of the above
e. All of the above.

2. Glass fragments greater than 2 millimeters in size will visualize on conventional films roughly what percent of the time?

a. 100%
b. 75%
c. 50%
d. 25%
e. 0%

(See answer on next page.)

Specialty Quiz Answer

The Emergency Medicine Quiz question is located on the previous page.

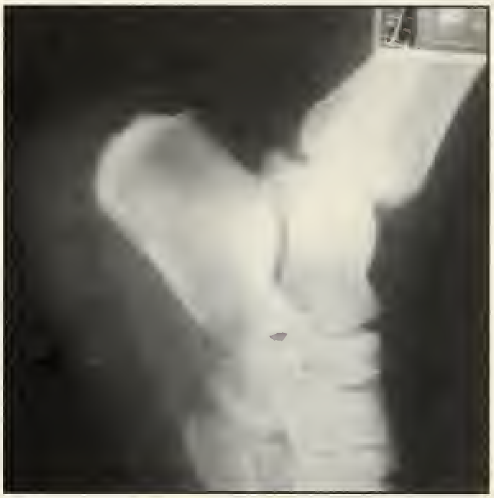

Figure 1 repeated

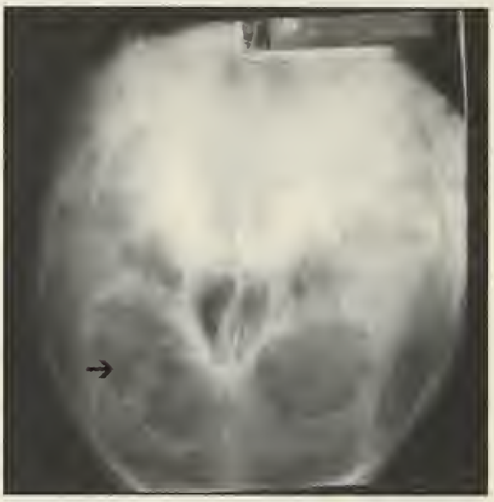

Figure 2 repeated

ANSWER: 1. d. None of the above. Glass will visualize on conventional radiographs regardless of source, whether or not it is leaded and whether or not it is pigmented.

2. a. 100%. Glass fragments two millimeters in size or greater will visualize on conventional films more than 99% of the time.

Glass is a frequent cause of wounds in patients who present to the emergency department. Glass detection can be difficult in some of these wounds. Undetected material can result in complications including delayed wound healing, infection, and tissue damage. As a consequence, undetected foreign bodies can be a medicolegal hazard for emergency physicians.

Plain radiographs can help confirm the presence or absence of glass in cases where wound exploration is difficult. Many physicians have had the misconception that glass will not visualize on conventional x-ray unless leaded. In fact, most radiology textbooks prior to 1987 state that glass must have lead content to appear opaque. This was despite the fact that there was good data to the contrary in the late 1970s and early 1980s. Studies have shown that pieces of glass two millimeters in size and greater can be detected on radiographs nearly 100% of the time, regardless of whether the glass is leaded or pigmented.

The indications for obtaining x-rays in glass caused wounds have not been well defined. In one retrospective series of 430 consecutive patients with a total of 578 wounds caused by glass, glass was found by examination in 7% of the wounds. Wounds with the highest prevalence of retained glass were puncture wounds and those caused by stepping on glass or due to a motor vehicle accident. Puncture wounds more often contained glass at emergency department presentation than did lacerations and patients with the perception that glass remained in the wound were also more likely to have retained foreign body.

Based on the available data, this author recommends that x-rays be obtained if a glass caused wound can not be fully explored (i.e. the bottom visualized) or if the patient has a foreign body sensation. Puncture wounds secondary to glass should generally be x-rayed because they are, by definition, difficult to explore. Wounds on the sole of the foot from stepping on glass or on the face from motor vehicle accidents are at highter risk for glass retention and should be strongly considered for x-ray examination. MoMed

References

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3. Tandberg D. Glass in the hand or the foot: will an x-ray show it? *JAMA* 1982;248:1868-1874.
4. Avner JR, Baker D. Lacerations involving glass: The role of routine roentgenograms. *AJDC* 1992;146:600-602.

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In The News

Susan E. Mackinnon, MD, professor of plastic and reconstructive surgery, otolaryngology, and occupational therapy, received a $1,317,725 four-year grant from the National Institute of Neurological Disorders and Stroke for a research project titled "Nerve Allotransplation for Traumatic Nerve Injury."

Dennis W. Choi, MD, PhD, professor of neurology and neurological surgery, received a $1,303,800 five-year grant from the National Institute of Neurological Disorders and Stroke for a research project titled "Nervous System Development and Injury."

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James Pennoyer, MD, 85, Webster Groves, died September 21, 1997. Dr. Pennoyer specialized in obstetrics and gynecology. He was a member of the Missouri State Medical Association.

Thomas W. Parker, MD, 79, St. Louis, died September 24, 1997. Dr. Parker, an internist, was a member of the Missouri State Medical Association.

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9 - *St. Louis:* Hyman R. Senturia Lecture, to be announced. Call R. Gilbert Jost, MD 314-362-7130.

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Journal of the Missouri State Medical Association

December 1997

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On the Cover: *"Flower Bed" - watercolor by Laura Horochowski, Bloomington, IN, formerly from Columbia, MO.*

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Editor's Desk

Happy Holidays Means Kids in the Back Seat, With Their Belts Fastened

J. Regan Thomas, MD

The holiday season brings with it trips to the mall, increased attendance at social events, and increased travel to visit friends and family. Overall, more of our patients will be spending more time in their cars. The holidays bring an increase in auto accident rates and injuries.

Important health advice for our patients will again be a reminder to use seat belts and take appropriate precautions for safe driving. That brings with it considerations about air bags. It should be reiterated that air bags reduce fatalities. That is in all categories except in children under 10 years of age.

A report in *JAMA* recently again confirmed the usefulness of air bags showing a significant reduction in crash fatalities. They published reports showing 18% fewer fatalities in frontal crashes in cars with passenger air bags. A breakdown for gender and age groups was interesting to note. Women had a 12% reduction in fatality if their car had air bags. Men had an even greater protective effect with a 23% reduction in deaths. Senior passengers 65 years and older saw a 6% reduction of fatalities associated with frontal crashes.

Hopefully most patients understand that their best chance of surviving a crash is to have their seat belt properly fastened. However, the air bags are advantageous even to those foolish enough not to use their seat belt. Air bags reduce the death rates for adult passengers not using their seat belt by 23%. Those properly belted, however, had an additional 14% survival rate.

Hopefully most patients understand that their best chance of surviving a crash is to have their seat belt properly fastened.

This is good news for all groups except children under 10 years of age. The Insurance Institute for Highway Safety, who did a study reported in last months *JAMA*, noted that more children were killed than saved by air bags during the period studied from 1992 through 1995. The authors of the study cited 11 deaths in children and three infant deaths during the study which were attributed to air bags. Overall fatalities were 34% higher than expected in children under 10 years old. *AM News* noted in their report that most children deaths came when children were unbelted or improperly belted. The study's authors encourage manufacturers to develop air bags that are deployed with less force as well as to encourage stronger seat belt restraint-use laws. Past studies have demonstrated that the safest place for children in an automobile is in the back seat with seat belts properly fastened.

Air bags have been an important contribution to passenger safety. The National Highway Traffic Safety Administration estimates that driver-side air bags have saved more that 1,600 lives and passenger-side air bags have saved nearly 200 lives through February of this year. An important development indeed. None the less, kids should be in the back seat with seat belts fastened. The holidays will be happier that way. MoMed

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The Holiday Season

A.J. Campbell, MD

The holiday season is a time of celebration, thanksgiving, and new beginnings. It is a time when we surround ourselves with family and friends and enjoy those we love and the many blessings we have received. It is a time of reflection, too, even in the midst of the hustle and bustle, the parties and gifts and visitors; it is a time when many of us try to stop and experience the wonder and gratitude which the season truly embodies.

It is in this light that I invite each of us, as physicians, to pause and be thankful for the unique privilege that has been granted to practice the still noble art of medicine. We have ended up where we are by some specific combination of hard work, perseverance, and good fortune. Each of us, through whatever circumstances, has been given the opportunity to help our fellow men, bring comfort, and alleviate suffering. What greater privilege can there be?

We are granted unique access to the lives, ills, and fears of our patients and their families. We have developed our skills and trained our hands and eyes to assess, our minds to treat, and our hearts to comfort. Even when we find this draining or begin to experience burn out, we acknowledge that these are the great rewards of our profession, and these are the things that keep us motivated in a world of business considerations, contracts, and loss of professional autonomy. We still see ourselves as healers and that is what called us to the profession in the first place.

We can be thankful and proud as we reflect on how rich our lives have been because of the opportunity to care for patients. I think, too, that the knowledge of this richness of experiences is part of what underscores the deep camaraderie we experience with other physicians and their families . . . they understand not only the inconveniences and the loss of family time and how it feels to get called out at all hours, but also the satisfaction associated with helping others, and in having skills and knowledge to be able to do so. We revere the intimate connection and the bond formed when another human being puts his or her trust in us as a physician.

So, I call on all of us to pause and remember that despite the fact that our patients and our profession are under siege by corporations which answer to Wall Street, we as physicians still answer ultimately to our patients, and that this is a privilege very few in this world will ever experience or fully understand.

We need to fight to preserve this privilege by continuing to advocate for our patients rights to choose and receive excellent care from their physician. As I have continued to remind you throughout the year, our best efforts to preserve the rights of our patients and the autonomy of our profession come when we work together through organizations like MSMA, to combat the "bottom line only" approach to the healing art of medicine. Again, I encourage your active participation and your efforts to recruit new members, whose interests are also best served through an organization which can work to defend their patients, represent their concerns to the legislature, provide CME opportunities, and provide a rich network of colleagues who have also been granted the unique blessing and opportunity of serving others through the practice of the art and science of medicine.

I wish you all a joyous and safe holiday season and ask that we reflect again on what a wonderful privilege and responsibility we've been granted. MoMed

Sandra Mitchell Honored by the Metropolitan Medical Society of Greater Kansas City

Carol Jean DeFeo

The Metropolitan Medical Society of Greater Kansas City awarded Sandra Mitchell, Immediate Past President of the American Medical Association Alliance, its Lay Honor Award at its recent business meeting. The Lay Honor Award was established in 1944 as a means to recognize non-physicians who have made outstanding contributions to the advancement of good medical care and public health. This award has been presented only twenty-one times in its 53-year history. MoMed

Carol Jean DeFeo, left, Metro Med Alliance President and Steve Buie, MD, right, Metro Med President, present the Lay Honor Award to Sandra Mitchell, center.

The following MSMA members have contributed to the American Medical Association Education and Research Foundation (AMA-ERF) in lieu of Holiday Greetings.

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1982 Supreme Court Decision Destroys Fee-For-Service Fosters HMOs with Financial Incentives

Arthur H. Gale, MD

In 1982, the U.S. Supreme Court in a four to three decision ruled that the Maricopa and Pima County medical societies in Arizona could not form a medical foundation which set maximum (not minimum) fees.

By setting up a medical foundation, the Maricopa County medical society wanted in the Court's words, "to provide the community with a competitive alternative to existing health insurance plans." The doctors wanted to preserve fee-for-service medicine. Health insurance companies were willing to negotiate with the foundation because under such a system they could better predict their costs.

The goals of the Maricopa County doctors were laudable. How many times have physicians heard from colleagues and the public that doctors have brought on their own problems because of exorbitant fees charged by some physicians. The Maricopa County doctors simply wanted to eliminate that problem. Competition would be preserved because physicians would still be able to set fees as low as they wished.

The Court, however, ruled that any price fixing including the setting of maximum fees was a per se violation of the Sherman Antitrust Act. The term per se essentially means the literal interpretation of any law. In the case of the Sherman Act, a per se interpretation would mean that any and all forms of price fixing are prohibited.

The defendants and the minority of the Court (Powell, Rehnquist, and Chief Justice Burger) believed that the rule of reason not the per se rule should apply. Justice Louis Brandeis provided the classic definition of the rule of reason. Boiled down to its basics, it means in antitrust cases that if the intent and outcome of price fixing promotes competition, it is legal. Rule of reason also allows facts unique to the particular case to be brought before the court. The minority opinion cited precedents where price fixing was ruled legal according to the rule of reason.

If the views of the minority had prevailed, if one vote of the Supreme Court had been changed, the takeover of American medicine by HMOs and managed care companies might never have occurred. A significant role for fee-for-service medicine might have been preserved.

Justice Powell writing the dissenting opinion made some telling comments and issued some stern warnings, "Medical services differ from the typical service or commercial product at issue in an antitrust case. The services of physicians . . . rarely can be compared by the recipient. A person requiring medical service or advice has no ready way of comparing physicians or shopping for quality medical service at a lesser price. Primarily for this reason, the foundations . . . perform a function that neither physicians nor prospective patients can perform individually . . . We thus have a case in which we derive little guidance from the conventional 'perfect market' analysis of antitrust law. I would give greater weight than the [majority] Court to the uniqueness of medical services, and certainly would not invalidate on a per se basis a plan that may in fact perform a uniquely useful service . . . It is unwise for the Court, in a case as novel and important as this one, to make a final judgment in the absence of a complete record."

In essence, the dissenting judges warned the Court majority that since medical care was unique and unlike the manufacturing and marketing of commercial products, their ruling could have unintended harmful consequences. Now 25 years later with managed care firmly entrenched, events are bearing out their well-founded concerns.

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There is another legacy of the Maricopa decision which has had an even more destructive impact on health care and the doctor-patient relationship than just the elimination of fee-for-service.

The Court advocated a revolutionary and untried method of health care delivery – HMOs, capitation, and physicians, not insurance companies, assuming financial risk when caring for patients.

The Court's opinion stated, "Most health insurance plans are of the fee-for-service type. Under the typical insurance plan, the insurer agrees with the insured to reimburse the insured for 'usual, customary, and reasonable' medical charges. The third party insurer, and the insured to the extent of any excess charges, bears the economic risk that the insured will require medical treatment. An alternative to the fee-for-service type of insurance plan is illustrated by health maintenance organizations authorized under the Health Maintenance Organization Act of 1973 . . . Under this form of prepaid health plan, the consumer pays a fixed periodic fee to a functionally integrated group of doctors in exchange for the group's agreement to provide any medical treatment that the subscriber might need. *The economic risk is thus borne by the doctors."* (italics mine)

To my knowledge this is the first time that the Supreme Court ever applied the concept of physicians' assuming economic risk to health care. The legal foundation upon which the Federal Trade Commission (FTC) manages health care is based primarily upon this one sentence. Unfortunately, most of the ethical problems faced by managed care today can also be attributed to this one sentence.

The Court's pronouncement on "alternative to the fee-for-service type of insurance plan" reflects its political and social agenda in fostering HMOs, capitation, financial incentives, and physicians' assuming financial risk. It illustrates the Court's self-appointed role as social engineer imposing a health care delivery system upon the American people without their prior approval. It also illustrates the Court's limited knowledge of the success of HMOs in reducing costs up until 1982 when the Maricopa decision was rendered. Had the Court taken the position of the dissenting justices and followed the rule of reason they might have learned some interesting facts.

The Health Maintenance Organization Act of 1973 was enacted under the Nixon administration. Nixon hailed from California. His advisers cited the Kaiser Permanente physician sponsored HMO as a cost cutting paradigm for future health care delivery. However, numerous studies in the 1970s and 1980s failed to show that HMOs reduced costs. Doctors practicing in group model HMOs like Kaiser reduced hospitalization days by up to 40%. But outpatient utilization increased and ultimate cost savings were insignificant. The conclusion to be drawn from the studies of the '70s and '80s was that when doctors practiced according to their best medical judgment there were no significant cost differences between fee-for-service and HMOs.

This conclusion is as true today as it was in the 1970s and 1980s. Two recent studies tracking medical costs (*Health Affairs,* Fall 1996 and July, August 1997) show that cost reductions in recent years under fee-for-service just about matched the drop in costs under HMOs. The most likely reason for this surprising finding is that most physicians, no matter under what plan they practice, admit fewer patients to the hospital for shorter stays then they did in past years. Yet managed care dogma states unequivocally that fee-for-service is the culprit responsible for high medical costs despite the lack of evidence to support this notion.

In Maricopa, the Court's comments on risk assumption by doctors applied primarily to staff model HMOs with which the justices were familiar. Staff model HMOs like Kaiser dominated the market in 1982. The Court declared "the consumer pays a fixed periodic fee to a functionally integrated group of doctors . . . The economic risk is thus borne by the doctors."

The FTC and commercial HMOs have taken this restrictive definition of risk out of context and expanded it. Under present day managed care, risk pools are set up which include doctors who are not functionally integrated. The Department of Health and Human Services (HHS) has taken the concept of risk even further in Medicare HMOs. The individual doctor is at financial risk for his panel of patients. If, through no fault of his own, he encounters seriously ill patients whom he must admit to the hospital, he can be personally liable for tens of thousands of dollars.

When doctors work under financial risk they have a strong temptation to withhold necessary care which can result in patient harm. It is no wonder then that the three largest not-for-profit HMOs including Kaiser, have joined with consumers in backing sweeping regulations to control the abuses of managed care which include financial incentives (*New York Times*, Sept. 25, 1997). One of the standards being sought by Kaiser and the other non-profit HMOs is, "Health plans should not pay doctors in any way that directly encourages them to limit medically necessary care." Ironically, this swipe at financial incentives is a direct repudiation of the goals of the Supreme Court (and FTC) by the very organizations which served as the model for the Maricopa decision.

If the Supreme Court were to assess today the managed care revolution which it helped initiate, its members might be shocked. They might be shocked at how their well-intentioned decisions played a decisive role in the breakdown in the bond of trust between doctor and patient. They might be shocked at how the FTC, HHS, and commercial insurers have expanded and distorted their original concept of risk and installed financial incentives which pervade almost every aspect of the doctor-patient relationship. They might be shocked by the actions of an angry public attempting to enact 2,000 pieces of legislation in order to regulate the managed care revolution which they helped spawn. They might be shocked that the very HMOs which served as the model for their opinion in Maricopa are asking for "legally enforceable national standards" to restore the public's confidence in managed care.

The Supreme Court might well be shocked by these events but the justices should not be surprised. The managed care revolution for which their opinions helped pave the way has something in common with the failed revolutions which occurred earlier this century in the Soviet Union, Italy, and Germany. All of these revolutions placed the goals of society – "the common good" – above the rights of the individual. In the case of managed care, the benefit to society of reducing medical costs is deemed a goal more worthy than the health of an individual who may require expensive care. The current backlash against managed care is the public's way of telling the Court and the proponents of managed care in government and the private sector that they will not accept that goal. They are telling the social engineers of the last three decades loudly and clearly that this is not the American way. MoMed

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The Adoption Choice

Sanford P. Krigel, Esq.
Karen Schneider Rosenberg, Esq.

When faced with an unplanned pregnancy, a woman must often make some difficult decisions. Some women choose to make an adoption plan for their child. This can be a difficult time for a birthmother and she may need her physician's support and assistance to guide her through the adoption process.

Adoption laws and procedures can differ widely in each state. The Missouri legislature recently passed the Omnibus Adoption Act which makes several changes to Missouri's adoption laws. This article will focus on adoption laws and procedures in Missouri and how such laws and procedures impact the birthmother in an adoption situation.

Types of Adoption Available in Missouri

A birthmother may want to have some communication or contact with the adoptive family. This type of an adoption is generally referred to as an "open adoption." An open adoption may include an exchange of letters, photographs, or a face-to-face meeting between the birthmother and the adoptive parents.

Under the new Missouri adoption law, a Court cannot prohibit an exchange of identifying information or contact between an adoptive parent and a birthparent. After the adoption is finalized, however, any further contact is at the adoptive parents' discretion.

It is extremely important, however, to check with local practices and procedures in each county. Many Missouri judges, in the past, have not allowed an exchange of "identifying information," such as last names and addresses. Some judges preferred to monitor or limit any contact between the birthmother and the adoptive parents.

Another type of adoption is usually referred to as a "traditional" or "confidential" adoption. With this type of an adoption, there is no contact or communication between the birthmother and the adoptive parents. Some birthmothers prefer this type of adoption, as they wish to remain anonymous.

A birthmother may become involved in an agency adoption or an independent identified adoption. Generally speaking, agency adoptions tend to be more "traditional" and "confidential" whereas independent adoptions tend to be more "open."

An agency adoption is where a licensed child-placing agency has been given custody of the child with the birthmother's consent. The agency, upon approval of the Court and entry of an Order, transfers custody of the child to the prospective adoptive parents, for the purpose of a subsequent adoption. The birthmother has either waived her consent to a future adoption of her child or has had her parental rights terminated by the Court, depending on the Court's procedures in the county where the adoption proceeding is pending.

An independent identified adoption occurs when the birthmother and/or adoptive parents work directly with an intermediary to formulate the adoption plan. Under Missouri law, a physician, an attorney or a clergyperson can act as an intermediary for the birthmother or the adoptive parents. Missouri law still requires that an investigation be made and a report submitted to the Court regarding the adoptive parents' suitability for the adoption and the child's background. Many judges also require that a report be submitted regarding the birthmother's decision to make an adoption plan for her child. Missouri law now requires that all persons granted the authority to place a minor child for adoption comply with the rules and regulations of the Missouri Division of Family Services in connection with the adoption. This includes physicians. Unless the physician is familiar with these rules and regulations, it is wise to contact a social worker or an attorney who is knowledgeable regarding these adoption rules and regulations.

In each of the adoptions described above, the adoption expenses are typically paid by the adoptive parents. Missouri law is very specific as to the expenses that can be paid in connection with an adoption. The adoptive parents can pay all the medical and hospital costs, legal expenses, foster care expenses, social worker/agency fees, and court costs in connection with an adoption. The new Missouri adoption law adds that the adoptive parents can pay for any other services the court finds are "reasonably necessary." The law does not define this phrase, so it will be up to the courts to interpret this section. It is not recommended that a physician accept a fee for serving as an intermediary in an adoption or for providing any services, such as counseling, that are not those typically provided for in pre-natal, delivery, and post-natal care.

Any type of payment or transfer of value in connection with an adoption not specified in the statute is illegal in Missouri and is considered to be a class C felony of trafficking in children. It is very important that the birthmother receive legal advice before accepting any payment or transfer of value from or on behalf of the adoptive parents as it could jeopardize the adoption and result in criminal prosecution.

The cost of an adoption varies depending on the circumstances. In Missouri, an adoption usually costs from $8,000 to $11,000. These costs are typically paid by the adoptive parents and include fees for the birthmother's physician, the hospital, attorneys, and social workers.

A physician who has a patient who wants to make an adoption plan should keep in mind the following:

- the physician may, with the patient's (birthmother's) permission, contact an adoptive parent(s) on behalf of the birthmother;
- the physician should then contact a social worker, licensed child-placing agency or an attorney who specializes in adoptions to formulate the adoption plan;
- the physician should not accept a fee or payment for serving as the intermediary;
- the physician should abide by traditional rules of confidentiality in connection with the adoption and the physician/patient relationship.

The Birthmother's Consent

In Missouri, a birthmother cannot consent to the adoption of her child until the child is at least 48 hours old. A birthmother who is a minor can consent to the adoption of her child. The Court should appoint a guardian ad litem for a minor birthparent to assist the Court in determining if the birthmother's consent is knowing and voluntary.

Under the new Missouri adoption law, the birthmother's written consent must state that she has provided the names of all possible birthfathers, unless she has good cause not to do so. It will be up to the judge to decide if good cause exists, as the phrase is not defined in the law.

The practices and procedures differ widely across the state as to the method used to obtain the birthmother's consent to the adoption and to the termination of her parental rights. The practices and procedures used in each adoption depend upon the county in which the adoption petition is filed. Missouri law provides that an adoption can be filed in any of the following counties:

- where the person(s) seeking to adopt resides;
- where the child sought to be adopted was born;
- where the child is located at the time of filing the adoption petition;
- where either birthparent resides.

Since the practices and procedures vary from county to county, it is best to seek legal counsel as soon as possible to be sure local rules and procedures are complied with in connection with the adoption.

In the Kansas City metropolitan area, the birthmother must execute a written consent and appear before the judge for a hearing, with her attorney, and request that the Court accept her consent to the adoption. The hearing occurs soon after the baby's birth, but not until the baby is at least 48 hours old. Until the birthmother's consent is accepted by the Court and the adoptive parents are given temporary custody of the baby, the baby resides in foster care.

In St. Louis City and County, the juvenile officer must request that the Court terminate the

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birthmother's rights. The birthmother must then appear before the judge for a brief hearing. The hearing is usually thirty to sixty days after the baby's birth. During that time period, the baby resides in foster care.

Once a birthmother consents to the adoption or her parental rights are terminated, she will receive no further notices regarding the adoption proceeding. It is extremely difficult for a birthmother to revoke her consent to an adoption and she should be advised that her decision is permanent and will terminate her legal relationship with the child.

The Birthfather's Consent

Missouri law also requires that the birthfather execute a written consent to the adoption. The law does provide, however, certain exceptions to this rule. For example, the birthfather's consent is not required if he has for a period of at least six months, for a child one year of age or older, or at least 60 days, for a child under one year of age, immediately prior to the filing of the adoption petition, willfully abandoned the child. The birthfather's consent is also not required if he has willfully, substantially and continuously neglected to provide the child with necessary care and protection, for the six month period prior to the filing of the adoption petition. (These exceptions to the rule also apply to the birthmother if she does not consent to the adoption.)

Also, if an alleged birthfather has not taken any affirmative act toward establishing his paternity, his consent is not required if he executes a statement denying paternity and disclaiming any interest in the child. Additionally, a birthfather's consent is not required if he fails to timely respond or make an appearance in an adoption proceeding, after proper notification of the proceedings. (Again, this rule also applies to a birthmother if she does not consent to the adoption.)

Conclusion

It is wise to contact an attorney in your area who is familiar with the practices and procedures of the local court regarding adoptions. Some judges, for example, do not allow independent identified adoptions or allow only the Missouri Division of Family Services to be the agency involved in an agency adoption. Also, judges differ as to the degree of openness that they allow in an adoption. Additionally, courts across the state differ as to the procedures used in an adoption for accepting a birthmother's consent and for terminating a birthmother's parental rights. These issues should be carefully considered by a birthmother who is contemplating adoption in the State of Missouri. MoMed

About the Authors

Sanford P. Krigel is a managing partner and shareholder of Krigel & Krigel, PC, located in Kansas City, Missouri. He has been practicing adoption law in Missouri for more than 20 years. He is a member of the American Academy of Adoption Attorneys. His practice includes representing adoptive parents, birthparents, and serving as a guardian ad litem in numerous adoption proceedings in the Kansas City area.

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Improving the Health of Missouri Communities: A Process Approach

Suzanne Stafford-Alewine, CHART Director
Missouri Department of Health

"As the 21st century approaches, Missouri's health care system is becoming dramatically different in the way it is financed, organized, and delivered. Significant scientific and technologic advances in the treatment of disease as well as governmental and market-driven health care reforms aimed at reducing costs, improving quality, and ensuring greater access to care for all segments of the population, have already occurred. Shifting into a population-based community health orientation, health care delivery systems are now soliciting community participation in identifying unique needs and priorities. Thus, the community serves an integral function in advising these organizations on how to create systems that deliver the appropriate kinds of health and social services for their community." (Williams & McCleary, 1997)

In response to the changing face of the health care system, the Missouri Department of Health and its statewide partners have collaborated to provide assistance to communities. This collaboration resulted in the development of the Community Health Assessment Resource Team (CHART), whose mission is to improve the health of Missourians. CHART assists communities in the assessment of their unique health needs and the development of community health strategies that are based upon that assessment. Such strategies allow communities to shift the focus from responding to acute crises to creating systems that plan for health, promote healthy behaviors, and provide services that are appropriate for their needs. The CHART process, established in July 1994, is built upon four tenets:

1. community involvement;
2. community commitment;
3. community control;
4. community benchmarks.

These tenets form the foundation of successful community initiatives statewide.

Community Involvement

Community involvement is the first cornerstone upon which CHART is built. Since CHARTs inception, the number of communities participating in the process has grown from 10 in July 1995, to nearly 70 in October 1997. The process is being actively used in nearly 100 Missouri counties. Staff at the Missouri Department of Health and the Missouri Hospital Association actively support these coalitions through the provision of technical assistance, training and education programs, data and resource materials, and as a focal point for establishing linkages with other coalitions addressing similar issues. In addition, the state partners are examining a recently completed evaluation of the CHART process to determine the best methods for supporting these community initiatives into the next century.

Community Commitment

The second cornerstone to the CHART process is community commitment. This commitment must be achieved if improved health status is to be attained. Through the development of broad-based coalitions, community commitment to the process for the long term is assured. With the assistance of the CHART partnership, Missouri communities have demonstrated the importance of becoming involved in this process. Community leaders have broadened perspectives about the definition of health to include not only physical health, but also the mental, social, religious, education, and safety aspects that impact quality of

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life. To ensure the continual development of community leaders, the CHART partners developed the Institute for Community Health Leadership. Organized as a resource for coalition leadership teams to receive intensive training around the CHART process, the Institute will graduate 77 Fellows in November 1997, and continues training for 50 new Fellows into Spring 1998. A new Fellowship class will begin in March 1998, with an anticipated enrollment of 50.

Community Control

Community control is the third cornerstone of the CHART process. In these times of placing decision-making power back into the hands of individual communities, their ability to impact decision-makers at the state and federal levels is greatly enhanced. Through local control and leadership, success is achieved, the best possible strategies for improving quality of life are developed, and community initiatives demonstrate tremendous success. Missouri communities are arriving at a point in the process that necessitates the development of community-based solutions to issues identified in the assessment phase. Communities face unique challenges in transforming their goals and objectives into comprehensive strategies. A vast resource bank of already developed and formally evaluated intervention programs exists, and communities are requesting technical assistance in identifying models most appropriate for their particular situation. The CHART partners are committed to assisting Missouri communities in identifying these best practices, and in guiding them toward resources that can be accessed for implementing community-based solutions.

Community Benchmarking

Benchmarking is the final cornerstone of the process. In order to measure success, communities must establish goals and engage partners in the community planning process. Coalitions are developing methods for establishing and attaining community goals. While data may not completely validate these methods and initiatives for a number of years, the fact that communities believe in the process is an indication that long term improvement will be achieved. The Missouri Department of Health is committed to providing communities with the best data possible for supporting their efforts. New methods of providing data communities are continually being developed, and the Department has implemented an extensive Internet site that provides county level data for many health status indicators. The CHART staff and state partners provide technical assistance to the community in establishing benchmark indicators, and in obtaining follow-up data for measuring the effectiveness of implemented programs.

Summary

It is important to note that while many states have communities involved in processes similar to CHART, few, if any, offer a team of professionals to support these initiatives, and none have a statewide partnership that is as committed to the process as Missouri does. The relationship between the key partner organizations is a unique phenomenon, and is certainly a key success factor for the process. CHART is an active member of the Coalition for Healthier Cities and Communities, a national network that exists as a multi-sector partnership to service the widespread communities movement in the U.S. The Coalition serves as both a link to resources, and as a voice for policy and action. The issues and concerns, as well as the successes, of Missouri communities are carried to this national Coalition to present a unified voice for communities nationwide.

CHART is an innovative approach to empowered community development. It provides communities the opportunity to participate in the process of change. The CHART process provides a vehicle for communities to take charge of the future, to determine locally how issues are addressed, and to set a course that assures improved health, quality of life, and sustainable community systems for the 21st century. MoMed

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Radiology Quiz #15

Roger A. Francis, MD
Radiology Department, Lake of the Ozarks General Hospital

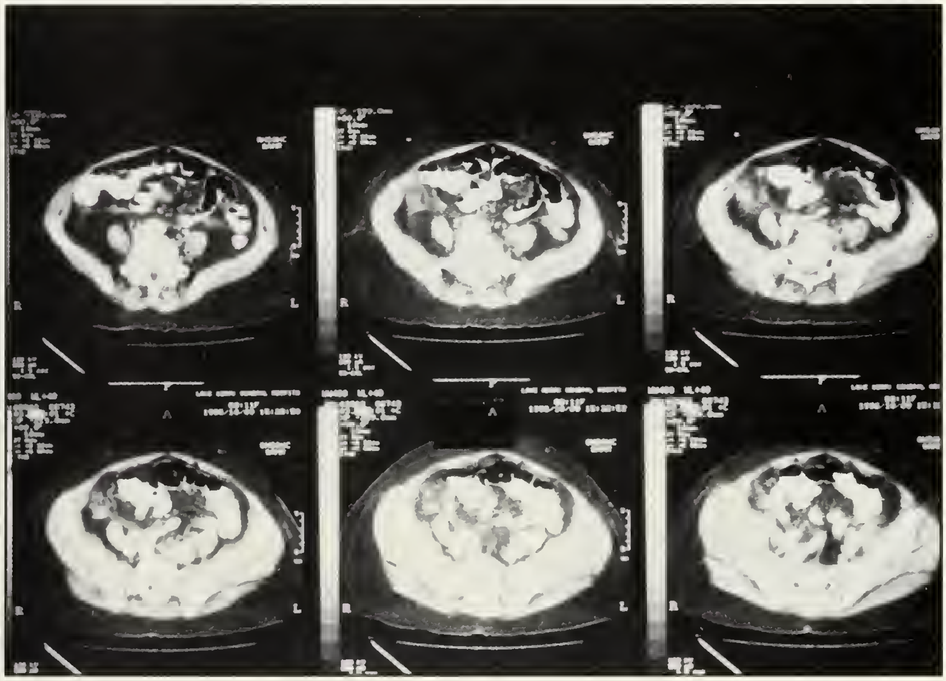

Figure 1

A 68-year-old female presented to clinic with a one day history of right lower quadrant pain. As part of the workup, a contrast enhanced C.T. scan of the abdomen and pelvis was performed (Figure 1).

What is the most likely diagnoses?

a. **Acute appendicitis**
b. **Ovarian cyst**
c. **Pelvic inflammatory disease**
d. **Granulomatous ileitis**

(See answer on next page.)

The Radiology Quiz question is located on the previous page.

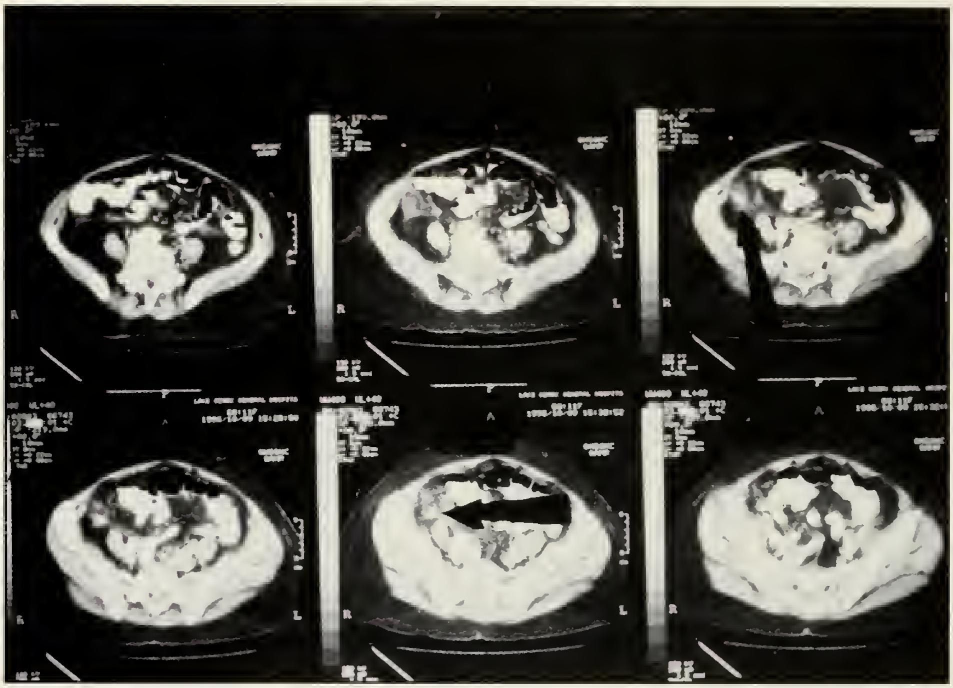

Figure 1 repeated

ANSWER: a. Acute appendicitis

C.T. slices through the lower abdomen (Figure 1) show a tubular structure (large arrows) oriented cephalocaudally in the right lower abdomen, extending for a distance of 7 cm inferior to the cecum (c). This structure measures 1.5 cm in greatest diameter, and appears to represent a thickened or dilated appendix (the normal appendix usually measuring less than 6 mm in cross sectional diameter). There is also some strandlike density (arrowhead) in the pericecal and periappendiceal fat, suggesting inflammation. No other abdominal mass, cyst or fluid collection is seen. Contrast opacified bowel loops do not appear dilated or thick-walled. The above findings are most suggestive of acute appendicitis without abscess. At laparotomy, the appendix was found to be inflamed, but no abscess collections were seen. Option "a" is therefore the correct diagnosis.

Options "b" ovarian cyst and "c" pelvic inflammatory disease are unlikely due to the age of the patient, and lack of documentation of pelvic abnormalities.

Option "d" granulomatous ileitis is unlikely since the distal ileum appears normal with no evidence of dilatation or wall thickening.

The diagnosis of appendicitis is usually a clinical one, but imaging studies may be helpful in atypical presentations to exclude other causes of right lower quandrant pain, especially gynecologic disease in young females. Plain films are usually non-specific in appendicitis, but may show a calcified fecalith in a small number of cases. Barium enema examination may occasionally be helpful by showing barium filling of the appendix which excludes appendicitis. However, non filling of the appendix may be a normal finding and cannot be used to diagnose inflammation. Ultrasonography of the right lower quandrant using a high frequency transducer and graded compression has been shown to have a high degree of sensitivity and specificity, showing a thick-walled, noncompressible appendix representing acute inflammation. However, ultrasonography is very operator dependent, and is not helpful in patients with acute perforation or marked bowel gas. C.T. scanning has been shown to have a sensitivity and specificity equal to or greater than ultrasonography, with less operator dependence. The C.T. diagnosis depends on visualization of an abnormal appendix, surrounding inflammation (as in the test case), or fluid collections indicating abscess.

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Continuing Medical Education Update

David S. Martin, MD, Chair
MSMA Commission on Continuing Education and Health Manpower
Ron Ellison, MBA
MSMA Director of Scientific Affairs

Missouri physicians have now received their 1998 License Renewal Form from the Missouri Board of Registration for the Healing Arts and are in the process of gathering their certificates to document the continuing medical education activities they have attended during 1997.

In order for physicians to renew their Missouri license, they must comply with the CME requirement. The minimum requirements for continuing medical education as stipulated in the Code of State Regulations, October 31, 1997, Supplement to Volume 1, October 1997-98, Section 4 CSR 150-2.125 are as follows:

> Each licensee, on a yearly basis, shall complete and report at least twenty-five (25) hours of continuing medical education. The Board shall not issue a renewal of a licensee's certificate of registration unless the licensee demonstrates completion of twenty-five (25) hours of continuing medical education accredited by the American Osteopathic Association (AOA) as Category 1-A or 2-A, by the American Medical Association (AMA) as Category 1 or Category 2 - as further specified in this rule, or American Academy of Family Physicians Prescribed Credit, in the immediately preceding reporting period. A maximum of ten (10) hours of AMA Category 2 education for which documented credit is given may be counted toward the twenty-five (25)-hour requirement.
>
> A licensee is not required to complete any continuing medical education hours in the renewal year following the year in which the licensee is initially licensed to practice the healing arts in Missouri if the licensee has not previously held a permanent license to practice the healing arts in Missouri or any other jurisdiction.
>
> The period for completion of the continuing medical education requirements shall be the twelve (12)-month period beginning January 1 and ending December 31 each year. A licensee who has failed to obtain and report, in a timely manner, twenty-five (25) hours of continuing medical education shall not engage in the practice of medicine unless an extension is obtained prior to December 31.

Currently, there are more than 2,600 institutions or organizations accredited by the Accreditation Council for Continuing Medical Education (ACCME) and state medical societies of which 65 are in Missouri. Only institutions and organizations accredited to provide continuing medical education (CME) can designate an activity for AMA PRA category 1 and category 2 hours.

Criteria for designating AMA PRA Category 1 credit:

An activity can be designated for category 1 if it is sponsored or jointly sponsored by an institution or organization accredited by the MSMA or ACCME and if the activity meets the following criteria as stated in the AMA's The Physician's Recognition Award, Information Booklet, May 1, 1996:

- It conforms to the AMA definition of CME.
- It conforms to AMA ethical opinions on Gifts to Physicians from Industry and on Ethical Issues in CME and to the ACCME Standards for Commercial Support of CME.

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- It is based on perceived or demonstrated educational need.
- It is intended to meet the CME needs of an individual physician or of a specific group of physicians.
- The educational objectives for the activity are stated.
- The content is appropriate for the specified objectives.
- The teaching/learning methodologies and techniques are suitable for the objectives and format of the activity.
- Evaluation mechanism are defined to access the quality of the activity and its relevance to the stated needs and objectives.
- There is documentation by the sponsoring institution/organization of physician participation.

Criteria for designating AMA PRA Category 2 credit

An activity can be designated for category 2 if it is sponsored by an institution or organization accredited by the MSMA or ACCME and if the activity meets the following criteria:

- It conforms to the AMA definition of CME.
- It conforms to AMA ethical opinions on Gifts to Physicians from Industry and on Ethical Issues in CME.
- It is designated by the unit responsible for the sponsor's accredited program.
- There is documentation by the sponsoring institution/organization of physician participation.

Effective July 30,1997, physicians renewing their Missouri license may claim AMA Physicians Recognition Award (PRA) Category 2 activities designated by institutions and organizations accredited by the MSMA or the ACCME. The designation of Category 2 by an accredited sponsor provides assurance to physicians that the lecture or conference has been evaluated and found to be an effective educational activity.

Sponsor designated conferences and workshops as AMA PRA Category 2 must not be confused with physician designated Category 2 learning experiences. The physician "self-designation" of Category 2 lectures and seminars, while meaningful learning activities, do not satisfy the CME requirement for relicensure. Physician-designated AMA PRA Category 2 activities may include:

- consultation with peers and medical experts;
- developing and reviewing quality assessment data;
- use of electronic data bases in patient care;
- use of enduring materials, small group discussions;
- self-assessment activities;
- journal club activities not designated AMA PRA Category 1;
- teaching health professionals;
- medical writing;
- teleconferences;
- preceptorships;
- lectures, seminars, and workshops not designated for credit.

Licensees who obtain American Specialty Board certification or recertification, participate in AMA- or AOA-approved internship or residency programs, or fellowships in approved teaching institutions during the reporting period are deemed to have met the 25-hour requirement.

Physicians may claim up to 50 hours of Category 1 credit per year of which 25 hours may be reported to the State Board of Registration for the Healing Arts for participation in a course of study leading to a medically related degree, such as a master's degree in public health or health care administration. The study must be offered by an institution accredited by the North Central Association of Schools and Colleges or another appropriate regional accrediting body.

Retired physicians are not required to obtain continuing medical education. A retired physician is one who has neither engaged in the active practice of medicine nor held him/herself out as an active practicing physician and filed with the board a retirement affidavit. However, a retired physician wanting to maintain a limited license (a practice that consists solely of the provision of gratuitous medical services) is required to obtain five (5) hours of AMA Category 1 or AOA Category 1-A or 2-A continuing medical education each calendar year.

To ensure that physicians received appropriate credit for time devoted to CME, the following information is needed for

AMA PRA Category 1 and/or Category 2 credit, renewal of license or other credentialing requirements:

- name of the accredited sponsor that designated the Category 1 or Category 2 credit. (In the event of joint-sponsorship, the accredited sponsor is the provider of CME credit. Joint sponsorship of Category 2 is not permitted.);
- location;
- activity title;
- exact dates of the educational activity;
- credit hours (physicians may claim credit hours only for their actual participation).

Physicians are required by law to keep a copy of their continuing medical education certificates for a period of three years in the event they are chosen to be audited by the State Board of Registration for the Healing Arts.

CME of the future will be accountability, purchaser, and patient driven, as opposed to the current mode, which is based on physicians' content preferences. Physicians at a grass roots level-the primary care physician in the community-are the ones who must develop this new model and must help local CME professionals in the process.[1] MoMed

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Pyatt RS. Impact of Managed Care on Continuing Medical Education. *The American Journal of Managed Care* 1996;2:1447-1458.

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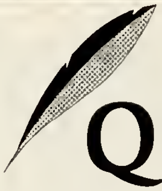

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Send to: Michelle Poire, Managing Editor, *Missouri Medicine*, MSMA, 113 Madison Street, P.O. Box 1028, Jefferson City, MO 65102. For questions, call 573-636-5151 or E-Mail at mpoire@plnet.net. Submissions and disks cannot be returned. Only one winner will be chosen. Winner and article will be announced and published in the April *Missouri Medicine*.

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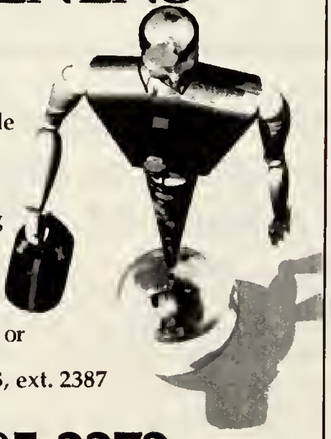

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Emergency Medicine Quiz #3

1998 Annual Convention Update

. . . plus much more.

Missouri State Medical Association

Annual Convention

April 16-19, 1998

Marriott Pavilion Hotel
St. Louis

Missouri State Medical Association

Annual Convention

Marriott Pavilion Hotel, St. Louis

General Sessions

April 16-19, 1998

Physicians as Leaders: Taking Charge of Health Care Through Quality and Education

Returning from a stellar performance at last year's MSMA Annual Convention, Robert Pyatt, MD, and Joseph Green, PhD, will challenge Missouri physicians to take charge of their own medical practices in 1998. A Must-Attend Presentation!

Dr. Pyatt is currently the Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians in Pennsylvania.

Dr. Green is Associate Dean of Continuing Medical Education at Duke University in North Carolina.

Friday, April 17, 1998
8:30-10:30 am

Medical Marriages

Roy W. Menninger, MD, will provide physicians and spouses with strategies to improve communications, balance demands of work and family, and grow and change constructively.

Friday, April 17, 1998
1:00 - 2:30 pm

Medical Ethics in the Age of Managed Care

Expert Panel
Presentation/Q & A

Saturday, April 18, 1998
10:00 am - Noon

MSMA Sponsored Annual Meetings and Events

Thursday, April 16

10:00-12:00 noon	Opening Session, MSMA House of Delegates
1:30 pm	MSMA Reference Committees

Friday, April 17

8:30 -10:30 am	MSMA General Session
11:00-12:30 pm	Open Forum on AMA Issues
1:00 - 2:30 pm	General Session
4:00-6:00 pm	Second Session, MSMA House of Delegates

Saturday, April 18

10:00-12:00 noon	General Session
6:00-7:00 pm	MSMA Presidential Inauguration
7:00-8:30 pm	MSMA Reception

Sunday, April 19

7:30 am	Final Session, MSMA House of Delegates Breakfast Meeting

. . . .

Preregister NOW!

The 1998 Annual Convention offers a large variety of educational activities. To assist you in attending these programs, please complete and return this convenient preregistration form.

Upon receipt of your preregistration form, we will send your confirmation card for you to present at the convention registration desk. Your registration packet and name badge will be awaiting your arrival.

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Jefferson City, MO 65102
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For more information, call 573-636-5151.

FAX BACK 573-636-8552

Name

Mailing Address

City/State/Zip

Component Medical Society

☐ *Delegate* ☐ *Member*

Christian Medical and Dental Society

Sunday, April 19, 1998 9:30 am

Scientific Program

Scientific Program
(sponsored by the Christian Medical and Dental Society)

9:30 am
Panel Discussion

Objectives: Not available.

Other Activitives
(sponsored by the Christian Medical and Dental Society)

April 18 - 7:00 am
Breakfast Meeting

Early Registration is Encouraged

Missouri Chapter, American College of Emergency Medicine

Saturday, April 18, 1998 8:30 - 11:30 am

Scientific Program

Scientific Program
(sponsored by the Missouri Chapter, American College of Emergency Medicine)

Moderator: Frank Zwemer, MD

Presenter: Dennis C. Whitehead, MD

9:00 - 11:30 am
How to Practice Emergency Medicine Without Going Crazy - Dennis C. Whitehead, MD

Objectives: Participants attending this session will be able to: 1) Identify major issues that will shape the practice of EM in the next five years; 2) Identify clinical and personal skills that will improve effectiveness for physicians; and 3) Identify policy impact on the practice of emergency medicine.

Other Activitives
(sponsored by the Missouri Chapter, American College of Emergency Medicine)

April 18 - 12:00 noon
Luncheon Meeting

American College of International Physicians

Saturday, April 18, 1998 1:00 - 5:00 pm Scientific Program

Scientific Program
(sponsored by the American College of International Physicians)

Moderators: Kul Aggarwal, MD
Ramesh Khanna, MD

Presenters: Ramesh Khanna, MD, Sharad Goel, MD, Madhuri Trivedi, MD, Jasleen Goel, MD, Mehdi Farhangi, MD, Amolak Singh, MD, Madhukar Misra, MD, Kul Aggarwal, MD

1:00 pm
Clinical Use of Diuretics: Treatment of Edema - Ramesh Khanna, MD and Sharad Goel, MD

1:30 pm
Hepatitis C: Update - Madhuri Trivedi, MD

2:00 pm
Autism in Children: What Can We Say? - Jasleen Goel, MD

2:30 pm
Breast Cancer: Hereditary Factors and What To Do About Them - Mehdi Farhangi, MD

Objectives: After attending this conference, participants will be able to: 1) Understand the role of diuretics in the treatment of edema and the problems associated with their usage; 2) Understand the implications of Hepatitis C; 3) Recognize the hereditary factors associated with breast cancer and practical points in managing these factors; 4) Recognize the various therapeutic agents that can cause renal failure and methods to reduce such risk; 5) Learn the applications of the recently available tool of Radiolabeled glucose imaging; 6) Understand the current concepts and practical management of autism in children; and 7) Understand the indications and methods of cardiac stress testing and the factors involved in choosing the appropriate type of stress test in individual patients.

3:30 pm
Radiolabeled Glucose Imaging: A New Diagnostic Tool - Amolak Singh, MD

4:00 pm
Renal Failure Due to Therapeutic Agents - Madhukar Misra, MD

4:40 pm
Cardiac Stress Testing: When and What Type - Kul Aggarwal, MD

Excellent Continuing Medical Education Activities

Missouri State Orthopaedic Association

Friday, April 17, 1998 7:30 pm Program

Program
(sponsored by the Missouri State Orthopaedic Association

Members will meet for cocktails and have an informal lecture on the issue of Manpower Reduction.

Missouri Psychiatric Association and Missouri Physicians Health Program

Saturday, April 18, 1998

Scientific Program

Scientific Program
(sponsored by the Missouri Psychiatric Association and Missouri Physicians Health Program)

Presenters: Sara C. Charles, MD

TBA **Stress Litigation** - Sara C. Charles, MD

Objectives: Not available.

Remember to Visit the Exhibits

Missouri Radiologic Society

Saturday, April 18, 1998 12:00 - 4:00 pm

Scientific Program

Scientific Program
(sponsored by the Missouri Radiologic Society)

Moderator: John Bedwinek, MD

Presenters: The Honorable Tim Harlen, Mr. James Kieffer, Tom Greeson, Esq., Harvey Tettlebaum, Esq.

Objectives: Participants will : 1) Learn the potential impact of Missouri State Legislation (with emphasis on the Managed Care Bill) on patient care; 2) Become familiar with the concept of Practice Management whether or not becoming involved with a Practice Management Corporation makes sense for Radiologists and Radiation Oncologists; 3) Learn strategies for retaining both control of patient care and financial autonomy.

12:00 noon
Impact of Missouri Managed Care Legislation on Patient Care - The Honorable Tim Harlen

1:00 pm
Independence from Hospitals through Practice Management Corporations - Mr. James Kieffer

2:00 pm
Who will have Control? Hospitals or Physicians? - Tom Greeson, Esq.

3:00 pm
Missouri Healthcare Legislation - Harvey Tettlebaum, Esq.

Other Activitives
(sponsored by the Missouri Radiologic Society)

April 18 - Times TBA
Breakfast
Luncheon

MSMA
1998 Annual Convention Deadlines

01-22-98 *Submission of Citizenship and Community Service Award Nominations*

This award honors a member physician who has made an outstanding contribution to the community for citizenship and public service above and beyond the call of duty as a practicing physician. Nominations should be submitted in writing to MSMA or through your local medical society.

01-22-98 *Submission of Commission and Committee Appointments*

Member physician names may be submitted for consideration of appointments to the MSMA many commissions and committees.

02-16-98 *Submission of Delegate and Alternate Delegate Cards*

Component Societies should be preparing to send a full contingent of delegates to the House. Each society will be notified as to the number of delegates they may send.

03-02-98 *Submission of Resolutions*

Resolutions may be submitted by individuals, component medical societies, or a group of member physicians.

Please mail the above to:
MSMA, PO Box 1028, 113 Madison Street
Jefferson City, MO 65102

Missouri State Medical Association MoMed Net

For an up-to-date Annual Convention program listing, visit us on the MSMA's Homepage. Information is revised upon receipt giving you the latest program available.

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3) Complete form located on the World Wide Web, http://www.msma.org.

Hotel Reservations

Hotel reservations should be made directly with the St. Louis Marriott Downtown.

Hotel deadline is March 2, 1998.

After this date, MSMA convention rates cannot be guaranteed.

Please compete the enclosed hotel reservation form or reservations also accepted by phone (314) 421-1776 or 1-800-228-9290.

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Exhibit Hall

The exhibit hall will be open Friday, April 17, 8:00 am until 5:00 pm and Saturday, April 18, 8:00 am until 2:00 pm.

Intermissions have been scheduled each day specifically for viewing the exhibits. This is in addition to the normal random viewing.

Attendance prizes will be awarded each day for member students and physicians having completed 60% of an attendance sheet.

Hotel Reservation Form

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Missouri State Medical Association
April 15th - 18th, 1998

Your reservations must be received prior to **March 2, 1998** and before the group reservations block is filled to assure your room accomodations.

PLEASE CHECK RATE REQUESTED

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☐ Triple Occupancy - 3 Persons	$113.00
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REQUESTED ROOM TYPE

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☐ Non-Smoking
☐ No preference

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☐ 2 Double Beds
☐ No preference

- Reservation request is subject to availability. There is a limited number of rooms set aside for your group.
- Reservation requests will be accepted on a first come - first serve basis.
- In the event rate or room type requested is not available, nearest available rate or room type will be assigned.
- Alternate hotels will be assigned as necessary.
- All rates are subject to state and local taxes.
- Guest rooms will be available for check-in after 4:00 pm. St. Louis time.
- Check-out time is 12:00 noon.
- If paying by check, please include total of first and last night's deposit.

Proposed MSMA Constitution Changes

The following proposed changes in the MSMA Constitution were presented at the 1997 Annual Convention and will be voted on during the 1998 Annual Convention at the First House of Delegates. In accordance with the MSMA constitution, these proposed changes must be published twice before being voted on.

Article V. Council.
It shall consist of....and the duly elected Councilors from the Medical Student Section, the Resident Physicians Section, ~~and~~ the Organized Medical Staff Section, and the International Medical Graduate Section.

Article VIII. Officers.
Section 2. The Delegates from the Medical Student Section, the Resident Physicians Section, ~~and~~ the Organized Medical Staff Section, and the International Medical Graduates Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor.

As 1997 comes to a close, we would like to thank all the display advertisers who have supported our efforts throughout the year.

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Physician Rights

Patrick J. Mills, MBA, CPA
MSMA Director of Health Care Finance

Even though physicians dismiss very few patients during their careers, their right to do so is critical. A resolution on this topic was brought to the 1997 MSMA Annual Meeting. Its chief concern was that some managed care organizations in Missouri are not willing to allow physicians to discontinue a physician-patient relationship.

The following are relevant policies from the 1997 AMA Policy Compendium.

Principles of Medical Ethics (excerpt)
VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

Although the essentially contractual physician-patient relationship is rarely in writing because it is by mutual consent, a written notice is considered appropriate to terminate the physician-patient relationship.

A physician desiring to discontinue a physician-patient relationship should send a notice to the patient through registered mail. The notification letter should allow reasonable time for the patient to find another physician, such as 30-60 days. See Figures 1 and 2 for sample letters. Following the patient's initiation of a relationship with a different physician, provision for transferring the patient's medical records to the new physician's office should also be made.

Figure 1.

Date: ____________

Dear ________________ :

I will no longer be able to provide medical care to (you/your children). If you require medical care within the next ____ days, I will be available, but in no event longer than ____ days.

To assist you in continuing to receive medical care for (you/your children), we will make your records available to a new physician as soon as you authorize us to send them to that physician.

Sincerely,

______________ , MD/DO

Figure 2.

Date: ____________

Dear ________________ :

I find it necessary to inform you that I am withdrawing from further professional attendance upon you because you have persisted in refusing to follow my medical advice and treatment. Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you desire, I shall be available to attend you for a reasonable time after you receive this letter, but in no event for more than ___ days.

This should give you ample time to select a physician of your choice from the many competent physicians in this city. With your authorization, I will make available to this physician your case history and information regarding the diagnosis and treatment you have received from me.

Sincerely,

______________ , MD/DO

Source: AMA Medicolegal Forms with Legal Analysis

E-8.11 Neglect of Patient
Physicians are free to choose whom they will serve. The physician should, however, respond to the best of his or her ability in cases of emergency where first aid treatment is essential. Once having undertaken a case, the physician should not neglect the patient. Issued prior to April 1977; Updated June 1996. (I, VI)

E-8.115 Termination of the Physician-Patient Relationship
Physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured. Issued June 1996. (I, VI)

H-285.954 Physician Decision-Making in Health Care Systems
(1) that certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician practicing in a health plan, whether in primary care or another specialty, either unilaterally or with consultation from the plan. Such decisions include, but are not limited to, the following: (excerpt)

- Terminating a patient-physician relationship.

The hallmark of medicine is the physician-patient relationship. MSMA will begin a dialogue with the managed care organizations of Missouri to preserve the right to terminate a physician-patient relationship. **MoMed**

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Cerebral Air Embolism During Endoscopy

Georges Bou-Samra, M.D.
Patric J. Darby, M.D.
Gordon D. Christensen, M.D.

Case Report

The patient was a 66-year-old white male who complained of diffuse abdominal pain and discomfort. The patient underwent an EGD, colonoscopy, and an upper GI series; the endoscopy showed multiple ulcers over the pylorus and greater curvature of the stomach and the stomach biopsy was consistent for gastritis, but negative for malignancy.

Three to four weeks prior to admission, the patient lost approximately 40 pounds in spite of exhibiting increased abdominal girth. The abdominal distension, determined to be ascites, had sharply curtailed daily activities. Endoscopy with biopsies was repeated. Once again only benign tissue was obtained. A liver-spleen scan was also performed and reported as normal. The patient's medications on admission were Cimetidine, Lopressor, and Nitro-Bid. His past medical history included a myocardial infarction, 1991, and atherosclerotic coronary artery disease. His social habits included alcohol abuse which had been stopped approximately two years ago, although patient admitted to occasional drinking in an attempt to relieve his abdominal pain. He was a heavy smoker, but had stopped 12 years ago.

Upon admission, the patient's temperature was 36.5 Celsius orally; sitting blood pressure was 120/80, (pulse 100); supine was 122/78, (pulse 84); and standing was 102/70, (pulse 102). Respiratory rate was 20 per minute and the patient was in mild distress. The sclera were anicteric. There was a firm and fixed left supraclavicular node. Basilar crackles were heard in the lungs. The heart had a regular rhythm S1, S2, without gallop. The abdomen was distended. There was a fluid shift but no hepatosplenomegaly. The lower extremities demonstrated pedal edema.

His admitting laboratory data included: Sodium 133 meq/L (136-148); Potassium 4.1 meq/L (3.7-5.4); Chloride 94 meq/L (96-111); Carbon Dioxide 26 meq/L (23-33); Blood-Urea-Nitrogen 25 mg/dl (10-20); Creatinine 0.9 mg/dl (0.4-1.5); Glucose 89 mg/dl (70-110); Calcium 7.8 mg/dl (8.9-10.6); Phosphorus 2.3 mg/dl (2.5-4.8); Total Protein 4.9 g/dl (6-8.5); Albumin 2.7 g/dl (3.5-5.5); SGOT 29 U/L (3-48); Alkaline Phosphatase 79 U/L (50-136); Total Bilirubin 2.6 mg/dl (0.1-1.5); Prothrombin 12.2; Partial Thromboplastin Time 28.3; White Blood Count 9.9 K/cmm (4.5-11); Hemoglobin 10.5 g/dl (13.5-18); Hematocrit 32.5% (40-54); Platelet Count 245 K/cmm (150-450); Mean Corpuscular Volume 84 cmu (80-96). Paracentesis revealed pH 7.42 and albumin 1.6. At this time, serum albumin was 2.7. Unfortunately, the cytology samples sent to the lab were not received.

On day five, EGD was performed. The distal esophagus appeared very friable with diffuse erythema, suspicious of an esophageal stricture at the gastroesophageal junction. The stomach was erythematous with marked friability and erosions at multiple sites. Thickened gastric folds were noted throughout the stomach although the pylorus was not deformed.

On day eight, a second EGD was performed to rule out gastric carcinoma. During this procedure the patient suddenly developed respiratory distress. The patient lost consciousness, and suffered a major seizure. Corneal reflexes were present bilaterally and pupils were equally round (2 mm) and reacted to light with conjugate eye deviation to the right. The patient had bilateral Babinski and reflexes were depressed but symmetrical. The patient was decerebrate and responded to painful stimulus. He had no spontaneous movement. His heart had a regular rhythm, normal S1, S2, and no murmurs, or S3, S4. The abdomen was distended and hypertympanic. Arterial blood gas performed on 100% oxygen demonstrated: pH 7.37; pCO2 34; p02 173; and O2 saturation 99%. The patient was transferred to the Medical Intensive Care Unit and intubated.

An emergent CT scan of the head demonstrated an acute right cerebral hemispheric infarct with hemorrhage, as well as, small collections of gas within the right frontal lobe. Because of this finding, the patient was then sent for an emergent MRI. The MRI showed multiple emboli through both cerebral hemispheres, most on the right side and also over the pontine region (Figures 1-3). Despite supportive use of hyperventilation, decadron, and mannitol, the patient's neurological status continued to deteriorate. A repeat CT scan was performed which revealed infarction of the entire right hemisphere and part of the mesencephalon and subthalamic herniation and occult herniation on the right, as well as, multiple midline infarcts of the left hemisphere and 2 to 2.5 cm midline mass effect. An echocardiogram with bubble study was performed and it did not show any anteroseptal defect.

On day 11, the patient became unresponsive, his pupils were non-reactive, and brain stem reflexes were absent. There were no spontaneous respirations. On day 12, his family was informed of his grave prognosis and the family permitted an apnea study. The test was performed and the patient expired later the same day.

At autopsy, it was requested that the heart and its branches be examined "under water" in order that any air might be detected. No air was found in the heart, and the chambers were intact without any shunts from right-to-left. Adenocarcinoma of the stomach, diffuse, signet ring type (linitis plastica) was found, with ascites (6700 cc) containing malignant cells, regional node involvement with cecal wall, pancreatic, and gallbladder invasion. There was acute bilateral brain infarction with an estimated age of 36-72 hours, which was more consistent with arterial than with venous infarction. There was no evidence of an ASD or VSD. There was no thrombus or embolic material in the anterior or posterior Circle of Willis vasculature. Infarcted brain tissue (including pituitary) was found bilaterally.

Discussion

Cerebral gas embolism can cause a variety of disturbances, from confusion, changes in personality, headache, aphasia, vertigo, focal and sensory motor deficits, as well as, seizure, coma, and death. Cerebral air emboli are usually caused by trauma or by invasive procedure affecting one of the blood vessels. Some of these invasive procedures include thoracentesis, perineal air insufflation, pneumoperitoneum, surgery of the heart, lungs, sinuses, neck, brain, axilla,[1,2,3] venous and arterial catheterization,[4,5,6] cardiopulmonary bypass,[7,8,9,10,11] pneumoarthrography,[12] pneumo-orbitography,[13] scuba diving,[14,15] laparoscopy,[16,16,17,18,19,20] and hemodialysis.[21]

Continued on page 706

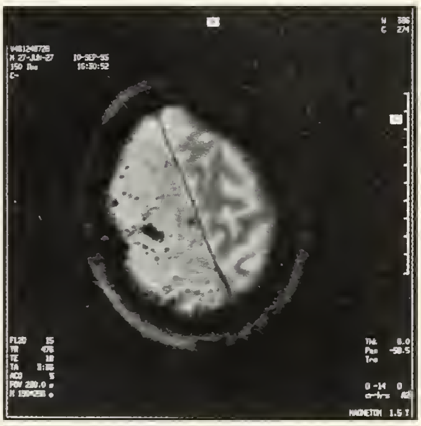

Figure 1.

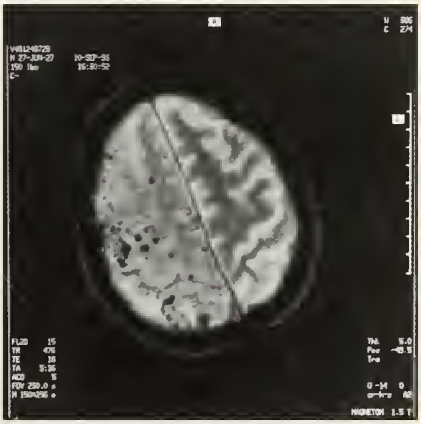

Figure 2.

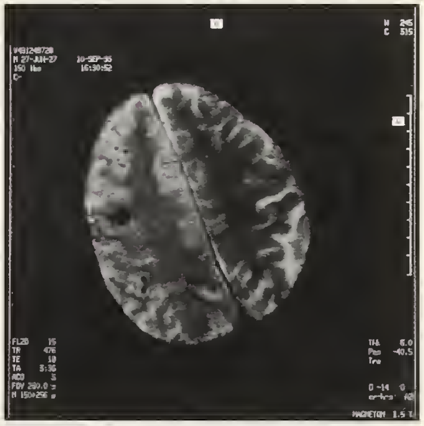

Figure 3.

Continued from page 705

In this case, the patient did not have any trauma, invasive procedures or central line access, and the emboli that were observed on radiologic studies, were immediately detected following the aborted EGD.

Air has been known to pass directly into the arterial system from a right-to-left shunt in the heart. An echocardiogram with bubble study performed shortly after the endoscopic procedure, failed to demonstrate an intracardiac defect.

Cerebral air embolism is a difficult diagnosis to prove, as air emboli within arteries vanish quite quickly. Once gas bubbles have entered the brain, ischemia is produced by direct vascular obstruction of blood vessels, by the air bubbles, and is followed by platelet and red cell aggregation, and increased capillary permeability. This mechanical obstruction is immediate and transient. Within minutes, the air moves through the capillary beds into the venules and is quickly dissipated. This event results in arterial spasm which is immediately followed by pronounced vascular dilation and transitory stasis of flow.[22,23,24] The emboli also cause damage to the blood brain barrier, with ensuing cerebral edema, in as little as thirty minutes.[25,26,27,28]

It has been posited, that during stomach insufflation, sufficient air may have permeated the blood vessels exposed by biopsy and/or one or more erosions. Furthermore, it has also been suggested that air might enter the circulatory system when a vein has been ruptured due to increased intra-abdominal pressure. Increased air absorption through necrotic tissue is also a possibility.[29] There have been cases reported where arterial air was observed after inadvertent venous air leaks. It is thought here, that the air might have traversed from vein to artery through the lung, by way of physiologic arteriovenous anastomoses.[20]

Although definite etiology is uncertain, we cannot disregard the fact that cerebral air emboli developed and were found within minutes following the aborted procedure. EGD has minimal complications that may occur in one out of 5,000 to 7,000 procedures, and this is usually due to over sedation. The chance of perforation or bleeding has been described as infinitesimal, since biopsies are but 2 mm. EGD is a safe procedure which has been performed tens of thousands of times without complications. In this particular case, a thorough review of the procedural techniques employed was scrutinized following the accident. The results of that study did not reveal any deviation from the normal routine operation. Several possibilities have been suggested which might have induced air emboli into the cerebral cortex during EGD. However, a thorough search and review of the literature indicated that this is the first report of cerebral air embolism occurring during endoscopy. Inasmuch, as this type of event has not been reported in the literature, further investigation into EGD procedure or technique would be unwarranted at this time. MoMed

The Authors

Dr. Bou-Samra is a Resident in the Department of Medicine. Dr. Darby is a Psychiatry Resident in the Department of Psychiatry and Neurology. Dr. Christensen is Professor of Medicine and Associate Chief of Staff for Research and Development. All physicians are affiliated with the University of Missouri-Columbia and Harry S.Truman Memorial Veterans' Hospital.

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The Use of Standard Management Reports In Medical Practice

Part III - Practice Expense

Tom Bennett, MBA, MDiv, MSW, GCG
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For the past two years earnings for HMOs have been flat and HMO premiums are projected to increase in the coming year by 4.6%. [1] It is more than likely, therefore, that HMOs in order to increase earnings will further squeeze the reimbursement rates for physicians and other providers. Practice expense is also expected to continue its upward spiral, with the net effect for many physicians in private practice being lower incomes/earnings.

This pattern of decline will surely continue, and physicians' practice profit margins may continue to decline until such time as they organize/integrate themselves, and develop new sources of revenue, e.g. ancillaries, gainsharing and risk contracting, and more importantly, until they engage in more effective ways of controlling their practice expenses.

At a recent physicians' organizational meeting, one of the authors was invited to address a group of physicians who were gathered to debate the merits of establishing a PHO with the local hospital. The stated purpose for the PHO was to enter into managed care contracting and direct contracting with local self-funded companies. Diverting the debate on PHOs and managed care contracting, the author was able to determine that of the 40 physicians present at the meeting, 35 were solo practitioners. It was further ascertained that these same 35 physicians were all paying for their own occupancy cost, phone systems, receptionists, billing systems, billers, coders and collectors, health insurance premiums, malpractice premiums, practice managers, accountants, attorneys and consultants, etc. Of these same physicians, 30 occupied space in the same medical office building owned by the hospital, and naturally all ancillary services/revenues went to the hospital. Ironically, each and every physician in that room claimed to be efficient!

The message/moral to the physicians on this particular evening was quite simple: "improve the management of the things that you have control over, rather than the things that you wish you had control over." They were advised to control practice expense first and foremost, find ways within the boundaries of the law to create new sources of revenue, and then PROACTIVELY engage managed care opportunities. In summary, it was suggested that the physicians should seriously consider starting their own Management Service Organization (MSO) and hire experienced professionals to manage and operate it.

Given the estimated, average practice expense of $120,000 per annum for each of the 35 physicians quoted above, the total practice expense, therefore, for all physicians may be estimated to be approximately $4,200,000. If these same 35 physicians could save 5% of this expense they would net $210,000, which could be used as financial justification to fund and operate their own MSO, or, at a minimum, consider using their collective bargaining clout to shop for a qualified MSO to provide services in lieu of the existing inefficient model.

A number of benefits would accrue to the group at very little cost, e.g. in performing due diligence, substantial exposure to current technology, organizational management structures, and strategic planning would be valuable regardless of whether they choose to form their own MSO or to outsource the functions to a qualified vendor. Furthermore, a strong case can be made for utilizing a vendor's services for an initial period of two years to ease the conversion in terms of organizational, system, and procedural changes. The obvious and compelling rationale for this exercise is the reduction of overhead expenses and increased income/earnings.

Overhead

There appears to be much debate over defining the term "OVERHEAD," and for purposes of this paper, overhead refers to "those non-physician expenses necessary to maintain and operate the medical practice."

Generally the items excluded from overhead are :
- physician salaries/earnings;
- physician benefits including life, health and disability;
- physician payroll taxes;
- physician CME/travel and entertainment;
- physician auto expense.

Nota Bene: professional liability insurance is included in the practice overhead because it must be paid in order for the physician to conduct business and practice medicine.

There is a real danger among physicians and practice managers to become obsessive about overhead, even to the point that more attention is paid to the actual ratio and the reduction of overhead, rather than increasing earnings/profitability for the practice.

Overhead is a relative ratio and simply a function of practice expenses divided by revenue. Is it, therefore, more beneficial to have a low rate of overhead at 40% with net income of $110,000, or a higher rate of overhead at 55% with net income of $130,000 per year? The latter, obviously, because the function of the expense should be to create revenue/income.

For purposes of illustration, the context of these reports is a multispecialty primary care group: Dr. Jones (OB/GYN), Dr. Smith (Internist), and Dr. Evans (Peds). Similar reports can easily be developed to capture information of significance for other specialities.

Please note: the data in the reports are used for illustration purposes only.

Report #1 Accounts Payable Report

Accounts payable (AP) should be thought of as the reverse of the accounts receivable system. The mechanism works the same way, except that instead of taking in money the practice will disburse it. The practice should therefore take as much care with accounts payable, if not more care, since money actually leaves the practice. Ideally accounts payable turnover should match accounts receivable turnover.[2]

An accounts payable system should be designed to:
- Track the amount the practice owes each vendor.
- Remind the manager when to pay in accordance with the purchase terms, the practice policy and availability of cash.
- Issue checks to the vendors.
- Tally checks paid to vendors throughout the year for reporting 1099 information.

The purpose of report #1 is to provide a basic ledger of expenses that is used to log/document the major payables by vendor, amount, invoice date, invoice number, due date, payment approval, payable date, and paid date. By utilizing this type of log/report, the practice may create a safety net that may preclude payables from slipping through the cracks, while ensuring that these payables have been accrued and justified.

Another important function of this report is to create a schedule for cash flow, and establish a payment schedule that will preclude the practice from being overdrawn due to large outflows of cash without sufficient funds to cover the obligations. According to Uwe Reinhardt, a nationally recognized health care economist, HMOs have used a deliberate policy of tardy payments in order to make significant interest on the "float." This practice by HMOs, therefore may force the practices to delay paying their accounts payable to 60 days and over, or even to reduce physicians' salaries/bonuses. In order to overcome this dilemma it is advisable to establish a line of credit (LOC) with the local bank. This LOC is generally secured by 75% of the estimated value of the accounts receivable along with the assets of the practice.

In reference to report #1 :
- The column heading "Approval" refers to approval to issue a check for payment. Before a check is issued the practice manager should verify that the goods/supplies were delivered intact and in the right quantity per the "receiver/packing" slip, which should be signed by the person authorized to receive the goods/supplies, and attached to the invoice.
- The column heading "Payable Date" creates a schedule for payment, however, the schedule may have to be adjusted contingent on availability of cash.
- The manager should verify that by September 23 there are sufficient funds to cover physicians' salaries, and in the event of a shortfall in cash, to transfer funds from the LOC to the checking account.

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- It should also be noted that there are $8,850 of expenses from the previous month that still have to be paid and it should be accrued along with the disputed amount of $11,200.
- There are eight major monthly cash outflows:
  1. staff wages which are paid bi-monthly;
  2. federal/state deposits for taxes on staff wages paid bi-monthly;
  3. physician salaries;
  4. federal/state deposits for physician taxes on salaries;
  5. rent;
  6. pharmaceuticals;
  7. insurance;
  8. loan payments.

This report may also be used as an adjunct report by the accountant in order to establish the accrued liabilities of the practice, and also to compile the income statement and the balance sheet. The report may also be used as a stand-alone report that is generated by the practice manager for the physicians' review each month. It is also a vitally important and practical working log/report for the practice manager.

The report in this example was formatted on Excel which can also sort/arrange the accounts payable by vendor, by date of invoice or by any other column heading. There is available on the market inexpensive software for accounts payable management, Quicken, Peach Tree or more sophisticated packages such as Mas-90, Platinum, and Great Plains.

Report #1 Accounts Payable Sept.

Payee	Description	Amount	Invoice Number	Invoice Date	Due Date	Approv	Payable Date
SWB	Local phone	$750	12345	4-Sep	15-Sep	Y	14-Sep
ATT	Long D phone	250	23456	6-Sep	16-Sep	Y	14-Sep
Labcom	Lab supplies	3,000	34567	5-Sep	5-Oct	N	15-Oct
Radcom	Xray supplies	1,000	45678	7-Sep	7-Oct	N	15-Oct
Merck	Vaccines	4,000	67891	8-Sep	8-Oct	Y	15-Oct
Wyerth	Vaccines	2,500	78912	9-Sep	9-Oct	Y	15-Oct
St. Mary's	Rent	4,666	89123	7-Sep	7-Oct	Y	15-Oct
St. Paul	Malpract Ins	2,270	91234	5-Sep	5-Oct	Y	25-Oct
Commerce	Loan	3,500	81234	7-Sep	21-Sep	Y	21-Sep
AUL Ins	401(k)	3,600	71234	8-Sep	23-Sep	Y	22-Sep
Prudential	Health Ins	1,400	61234	9-Sep	9-Oct	Y	15-Oct
Metlife	Life Ins	400	51234	9-Sep	9-Oct	Y	15-Oct
Peterson	Accounting	1,500	41234	10-Sep	10-Oct	Y	25-Oct
McPerson	Legal	1,800	31234	11-Sep	11-Oct	N	25-Oct
SWB	Yellow pages	250	21234	12-Sep	12-Oct	Y	25-Oct
MedAvert	Advert/Prom	1,250	22234	12-Sep	12-Oct	Y	25-Oct
Computech	Compt. serv	1,000	22233	13-Sep	13-Oct	N	30-Oct
PSS	Office sups	350	22244	14-Sep	14-Oct	Y	30-Oct
Mr Clean	Laundry	300	22255	14-Sep	14-Oct	Y	5-Oct
PSS	Medical sups.	2,500	33322	15-Sep	15-Oct	N	5-Oct
Phoenix	LTD	500	33311	15-Sep	15-Oct	Y	5-Oct
Staff	Wages	9,000	44411	16-Sep	16-Sep		16-Sep
Fed	Taxes/staff	1,800	55522	18-Sep	18-Sep		18-Sep
MO	Taxes/staff	600	55533	19-Sep	19-Sep		19-Sep
Staff	Wages	9,000	55544	30-Sep	30-Sep		30-Sep
Fed	Taxes/staff	1,800	66610	2-Oct	2-Oct		2-Oct
MO	Taxes/staff	600	66622	3-Oct	3-Oct		3-Oct
Butler	Auto leases	1,050	77722	16-Sep	16-Oct	Y	28-Oct
Physcians	Salaries	39,000	88833	23-Sep	23-Sep		23-Sep
Fed	Taxes/Phys	15,000	99944	25-Sep	25-Sep		25-Sep
MO	Taxes/Phys	3,000	54321	26-Sep	26-Sep		26-Sep
Ameritech	Beepers	75	21543	17-Sep	17-Oct	Y	10-Nov
Sub-total AP		117,711					
Prev. Month							
Merck	Vaccines	5,000	45678	12-Aug	12-Sep	Y	3-Oct
Labcome	Lab. supplies	2,800	56789	18-Aug	18-Aug	Y	5-Oct
Murray	Auto lease	1,050	78912	23-Aug	23-Sep	Y	8-Oct
Sub-total AP		8,850					
Disputed AP							
McPerson	Legal	4,500	89123	23-Jul	23-Aug	N	
SWB	Yellow pages	3,200	91234	24-Jun	24-Jul	N	
Wyerth	Vaccines	3,500	98765	2-May	2-Jun	N	
Sub-total AP		11,200					
Total AP		$137,761					

Report #2 Accounts PAID Report

The format of this report is very similar to Report #1, with the addition of the fields: "date of payment" and "check number."

The purpose of this report is to log and verify the invoices that have been paid. It is also an excellent method to verify the checks that have been issued, to whom, amount, date, and the check number. This report will become the instrument whereby the accountant compiles the income statement. Furthermore, the report also becomes an invaluable tool in balancing the check book and the bank statements.

For security and control reasons a policy and procedure should be established that would create checks and balances concerning the approval of payment of invoices, and the signing of checks for payment of the same invoices, and it is further recommended that those handling payables be bonded.

It is recommended that upon payment of an invoice, each invoice should be stamped "PAID" with the inclusion of the check number, the authorization signature, and date of payment. For planning and budgeting/auditing purposes this report may be formatted on Excel and can easily be sorted/arranged by vendor and amount etc.

Continued on page 712

Report #2 Accounts Paid Sept. 97

Payee	Descript.	Amount	Invoice Number	Invoice Date	Due Date	Approv	Payable Date	Check Number	Paid Date
SWB	Local phone	$250	23456	4-Aug	15-Aug	Y	14-Sep	10001	14-Sep
ATT	Long D phone	120	34567	6-Aug	16-Aug	Y	14-Sep	10002	14-Sep
Labcom	Lab supplies	3,500	45678	5-Aug	5-Sep	Y	15-Sep	10003	15-Sep
Radcom	Xray supplies	2,200	67891	7-Aug	7-Sep	Y	15-Sep	10004	15-Sep
Merck	Vaccines	5,500	45678	8-Aug	8-Sep	Y	15-Sep	10005	15-Sep
Wyerth	Vaccines	2,000	56789	9-Aug	9-Sep	Y	15-Sep	10006	15-Sep
St. Mary's	Rent	4,666	98765	7-Aug	7-Sep	Y	15-Oct	10007	16-Sep
St. Paul	Mal.Pract Ins	2,416	87654	5-Aug	5-Sep	Y	25-Sep	10008	25-Sep
Commerce	Loan	3,500	65432	7-Aug	21-Sep	Y	21-Sep	10009	21-Sep
AUL Ins	401(k)	3,600	54321	8-Aug	22-Sep	Y	22-Sep	10010	22-Sep
Prudential	Health Ins	1,400	43219	9-Aug	9-Sep	Y	15-Sep	10011	20-Sep
Metlife	Life Ins	400	32109	9-Aug	9-Sep	Y	15-Sep	10012	20-Sep
Peterson	Accounting	1,000	21098	10-Aug	10-Sep	Y	25-Sep	10013	20-Sep
McPerson	Legal	1,200	10987	11-Aug	11-Sep	Y	25-Sep	10014	25-Sep
SWB	Yellow pages	250	43421	12-Aug	12-Sep	Y	25-Sep	10015	25-Sep
Computech	Comput. serv	1,000	43567	13-Aug	13-Sep	Y	30-Sep	10016	30-Sep
PSS	Office sups	900	43678	14-Aug	14-Sep	Y	30-Sep	10017	30-Sep
Mr Clean	Laundry	275	56987	14-Aug	14-Sep	Y	25-Sep	10018	25-Sep
Medcom	Medical sups.	2,000	56712	15-Aug	15-Sep	Y	25-Sep	10019	25-Sep
Phoenix	LTD	500	90123	15-Aug	15-Sep	Y	25-Sep	10020	25-Sep
Staff	Wages	8,400	90345	16-Aug	16-Aug		16-Aug	10020	16-Aug
Fed	Taxes/staff	3,000	89000	18-Aug	18-Aug		18-Aug	10021	18-Aug
MO	Taxes/staff	600	75000	19-Aug	19-Aug		19-Aug	10022	19-Aug
Staff	Wages	8,400	65000	30-Aug	30-Aug		30-Aug	10023	30-Aug
Fed	Taxes/staff	3,000	86500	2-Sep	2-Sep		2-Sep	10024	2-Sep
MO	Taxes/staff	600	34900	3-Sep	3-Sep		3-Sep	10025	3-Sep
Butler	Auto leases	1,050	90000	16-Aug	16-Sep	Y	28-Sep	10026	28-Sep
Physcians	Salaries	39,000	90001	23-Aug	23-Aug		23-Aug	10027	23-Aug
Fed	Taxes/Phys	15,000	90123	25-Aug	25-Aug		25-Aug	10028	25-Aug
MO	Taxes/Phys	3,000	90234	26-Aug	26-Aug		26-Aug	10029	26-Aug
Ameritech	Beepers	75	90456	17-Aug	17-Sep	Y	26-Sep	10030	30-Aug
Total		$118,802							

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Report # 3 Budget Variance Report

This is a cumulative report for all three members of the practice. It may be run on a monthly or quarterly basis, and its purpose is to determine the impact of the profitability of the practice through budget variances.

The importance of this report is to compare actual performance for revenues, expenses and income to budgeted revenues, expenses and income. The budgets for revenue and expenses are based on trended historical data, adjusted for known and anticipated changes. In terms of expenses, all the major categories, or line items, are listed. For each major expense category there could be sub-categories that identify the expenses at the vendor level.

Since most physician's revenue is governed by fixed payment schedules from both the government and private payors, serious consideration should be given to compiling this report on an accrual basis as well as the traditional cash basis of accounting. This, would therefore, allow revenues and the adjustments to be recognized at the time services are rendered, and the associated expenses (cost) matched to these revenues,[3] thus providing the practice with more detail for planning purposes through trend analysis.

With reference to this report:

- It has been formatted to reflect current actual and budgeted amounts by month with monthly variance.
- The column "Previous Year YTD" is important because it gives the physicians and manager a further point of reference and comparison.
- It has been formatted to include income before taxes and depreciation (IBDIT).
- YTD income (IBDIT) is $565,797 and is significantly over budget by $60,453.

The major reason for this positive variance in income is that in January the group joined an IPA, and took advantage of its purchasing unit, and greatly reduced its expenses on malpractice, health insurance, pharmaceuticals, lab supplies, medical supplies, office supplies, computer services, and radiology supplies. To avoid such wide variances in income due to reduced expenses, it would have been advisable for this practice to adjust its expense projections after the first quarter, given the impact of the use of the IPA's purchasing unit.

Because of constraints of space, the formula for income distribution, and the allocation of variable, fixed, direct, and indirect expenses have not been addressed in this article, but will be addressed in a forthcoming article on "Income Distribution Methods."

Report #3 Budget Variance Report All Group Sept. 97

REVENUE	Budget Month	Actual Month	Var Month	Budget YTD	Actual YTD	Var YTD	Prev Yr YTD
Total Revenue	$137,000	$145,000	$8,000	$1,096,000	$1,100,000	$4,000	$1,060,000
EXPENSES							
Wages	24,000	23,500	-500	192,000	190,000	-2,000	184,000
Taxes/Staff	1,836	1,798	-38	14,688	14,535	-153	14,076
Health Ins	1,600	1,400	-200	14,000	12,000	-2,000	14,000
Dis Ins	600	500	-100	6,500	4,000	-2,500	6,000
Life Ins	450	400	-50	3,600	3,200	-400	5,500
401(k)	1,440	1,410	-30	11,280	11,000	-280	7,000
Malpract Ins	3,000	2,270	-730	30,000	24,000	-6,000	30,000
Car Leases	1,050	1,025	-25	6,500	7,200	700	6,500
Phone/Fax/AOL	1,200	1,500	300	9,600	8,500	-1,100	7,500
Beepers	90	75	-15	720	540	-180	650
Postage/Parcel	750	825	75	6,000	6,500	500	6,500
Office supplies	1,100	900	-200	8,800	7,500	-1,300	9,500
Medical supplies	3,500	2,500	-1,000	25,000	22,000	-3,000	23,000
Pharmaceuticals	7,000	6,500	-500	56,000	52,000	-4,000	50,000
RadiologySupplies	1,200	1,000	-200	9,600	9,000	-600	12,500
Lab supplies	3,500	3,000	-500	28,000	22,000	-6,000	18,000
Dues/membershp	800	850	50	6,400	7,500	1,100	4,500
Travel/CME	4,500	3,500	-1,000	12,000	10,000	-2,000	12,000
Computersup/serv	1,500	1,000	-500	12,000	9,000	-3,000	12,500
Laundry	250	300	50	2,000	1,900	-100	1,850
Meals/entertain	1,200	2,500	1,300	9,600	8,000	-1,600	7,500
Int. Expense	3,500	3,500	0	28,000	28,000	0	22,000
Rent	4,666	4,666	0	37,328	37,328	0	37,328
Legal	1,200	1,800	600	9,600	14,000	4,400	7,500
Accounting	1,000	1,500	500	8,000	8,500	500	8,500
Consulting	1,000	1,500	500	8,000	1,500	-6,500	4,500
Marketing/prom	1,500	2,500	1,000	12,000	11,000	-1,000	10,000
Periods/journals	150	175	25	1,200	1,000	-200	800
Miscel.	250	450	200	2,000	2,500	500	2,500
Total Exp	73,832	72,844	-988	590,656	534,203	-56,453	526,204
Inc. beforetax/depr	63,168	72,156	8,988	505,344	565,797	60,453	533,796
Deprec. Off.Equipt	2,500	2,500	0	20,000	20,000	0	20,000
Deprec. Med.Equipt	4,500	4,500	0	36,000	36,000	0	36,000
Income before taxes	56,168	65,156	8,988	449,344	509,797	60,453	477,796

Report #4 Summary of Expenses by Category and Percentage

This report is an extension of the Budget Variance report, and it consolidates the expenses into major categories as a percentage of the total expenditures.

With reference to this report, the major expenses of the practice include:

- Staff wages which account for 35.57% of the YTD total expenses.
- Rent at 7%.
- Pharmaceuticals at nearly 10%.
- Insurance at 8%.
- These four categories alone account for more than 60% of the expenditures of the practice.

Report #4 Summary of Expenses
Sept 97

Item	Amount	%
Wages	$190,000	35.57%
Insurance	43,200	8.09%
Pharmaceuticals	52,000	9.73%
Communications	24,540	4.59%
Lab supplies	22,000	4.12%
Radiology supplies	9,000	1.68%
Medical supplies	22,000	4.12%
Office supplies	7,500	1.40%
Rent	37,328	6.99%
Interest	28,000	5.24%
Professional services	35,000	6.55%
Other	63,635	11.91%
Total expense	$534,203	

This report allows the physicians a quick view of the major expenditures of the practice, and it may be compared to the payor mix on the revenue side. This report may also be graphically formatted in a pie chart.

Conclusion

These reports have been designed to provide a practical guide to physicians and practice managers in order to track expenditures and manage cash flow. The reports may also be useful for budgeting, strategic planning, and contracting purposes.

It is important to note that the practice's accountant, whose responsibility is to compile the income statement and the balance sheet, is totally dependent on the practice reports to provide him/her with accurate, timely, and verifiable information. The quality/accuracy of these financial statements is once again contingent on the reports/data generated by the practice, and become the basis for tax preparation. Therefore, it behooves the practice manager to work collaboratively with the accountant, and to design and use a set of management reports that may be interfaced with the accounting system used by the accountant. MoMed

The Authors

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In The News

Dennis W. Choi, MD, PhD, professor and head of neurology at Washington University School of Medicine in St. Louis, received a $50,000 Conference Grant from the National Institute of Neurological Disorders and Stroke for the "21st Princeton Conference on Cerebrovascular Disease."

C. John Ritter, MD, spent three months in Mozambique as a Methodist volunteer-in-mission at Chicuque Rural Hospital on the eastern coast. Physicians from five countries – the United States, Germany, Brazil, Nigeria, and Mozambique – were working at the hospital during Ritter's stay. Dr. Ritter treated a variety of cases including malnutrition, tuberculosis, malaria, hapatitis, AIDS, and land mine injuries.

In Memoriam

James Spencer Gordon MD, 69, Sedalia, died September 24, 1997. Dr. Gordon received his medical degree and completed his residency in Anesthesia at the University of Missouri-Columbia. He completed his internship at Kansas City General Hospital. He began practicing Anesthesia in Jefferson City in 1960 until his retirement in 1983. Dr. Gordon was a member of Alpha Omega Alpha, the American Society of Anesthesiologist, the Missouri Society of Anesthesiologist. He was a diplomat of the American Board of Anesthesiologist, a member of the American Medical Association, the Missouri State Medical Association, and the Cole County Medical Society.

Gerald J. Duling, MD, 63, St. Charles, died October 3, 1997. Dr. Duling, a Pediatrician, was a member of the Missouri State Medical Association.

Justin Kraner, MD, 75, Clayton, died October 13, 1997. Dr. Kraner received his medical degree from the University of Michigan Medical School and began his private practice in Obstetrics and Gynecology in St. Louis in 1954. He taught for several years at the Washington University School of Medicine were he was an assistant professor. Dr. Kraner was a member of the Missouri State Medical Association.

Suraj Prakash Ahuja, MD, 63, Leawood, KS, died October 15, 1997. Dr. Ahuja received his medical degree from Nagpur Medical College in India. He practiced Cardiology in the Kansas City area and was a clinical adjunct professor at the University of Missouri-Kansas City School of Medicine. Dr. Ahuja was a Fellow of both the American College of Cardiology and the American College of Physicians. He was a member of the Missouri State Medical Association.

Frank Ostapowicz, MD, 74, St. Louis, died October 30, 1997. Dr. Ostapowicz was a professor at St. Louis University School of Medicine and past director of Obstetrics and Gynecology at St. Marys Health Center. He was a member of the Missouri State Medical Association.

AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category 1 programs.

Wasif Almuttar, *Maryville*
George Bohigian, *St. Louis*
Michael Bukstein, *Hannibal*
John Cram, *Branson*
Robert Dell, *Hannibal*
Maureen Dempsey, *Columbia*
John Ferguson, *Springfield*
James Fleshman, *St. Louis*
Achenkunju George, *West Plains*
Paul Hoehner, *St. Joseph*
Robijn Hornstra, *Kansas City*
Lenworth Johnson, *Columbia*
Rolf Krojanker, *St. Louis*
Larry Legler, *Independence*
Dennis Motchan, *Bridgeton*
Margaret Nichols, *Joplin*
Marianne Prey, *St. Louis*
Carl Ringer, *Cape Girardeau*
Narendir Soorya, *St. Louis*
Sheridan Stevens, *Independence*
James Wolfe, *Springfield*

CME Listing

DECEMBER

6 & 7 - *St. Louis*: Craniofacial/Transfacial Skull Base. Call St. Louis University School of Medicine 314-577-8167.

6 - *St. Louis*: Contemporary Evaluation and Management of Valvular Heart Disease. 4 credit hours. Call Washington University School of Medicine 314-362-6891.

6 - *St. Louis*: Doctor - Hygienist: Team Success. Call Judith Brandes, St. John's Mercy Medical Center 314-569-6290.

8 - *St. Louis:* Magnetic Resonance Angiography of the Body. Call R. Gilbert Jost, MD 314-362-7130.

13 - *St. Louis*: Petrie Memorial Conference. Maternal/Fetal Med. Call St. Louis University School of Medicine 314-577-8167.

JANUARY 1998

12 - *St. Louis:* Non-Traumatic Emergency Chest Problems in Children. Call R. Gilbert Jost, MD 314-362-7130.

26 thru 30 - *St. Louis*: Medicolegal Death Investigator. Call St. Louis University School of Medicine 314-577-8167.

FEBRUARY

9 - *St. Louis:* Hyman R. Senturia Lecture, to be announced. Call R. Gilbert Jost, MD 314-362-7130.

MARCH

9 - *St. Louis:* The Role of Brain SPECT Imaging in 1998. Call R. Gilbert Jost, MD 314-362-7130.

14 - *St. Louis:* Hepatobiliary Disease. Call St. Louis University School of Medicine 314-577-8167.

19 & 20 - *St. Louis*: Bleeding Disorders. Call St. Louis University School of Medicine 314-577-8167.

APRIL

4 - *St. Louis*: Allergy for the Clinician. Call St. Louis University School of Medicine 314-577-8167.

13 - *St. Louis:* What's Right with Radiology? Call R. Gilbert Jost, MD 314-362-7130.

17 thru 19 - *St. Louis*: Mental Health and Aging. Call St. Louis University School of Medicine 314-577-8167.

20 thru 24 - *St. Louis*: Medicolegal Death Investigator. Call St. Louis University School of Medicine 314-577-8167.

23 thru 25 - *St. Louis:* Surgical Approaches to the Skull Base. 32 credit hours. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000

30 thru May 2 - *St. Louis:* Physician Liability. Call St. Louis University School of Medicine 314-577-8167.

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Mexico, MO 65265
Univ of KS-Kansas City 1992

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Columbia, MO 65201
Washington Univ-St. Louis 1987

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Jack Bridges, MD DR
5325 Faraon
St. Joseph, MO 64506
Univ of MO-Columbia 1988

James Poche', Jr., MD NS
3109 Frederick, #B
St. Joseph, MO 64506
Lousiana St Univ-New Orleans 1966

Steven Soper, MD P
910 Edmund
St. Joseph, MO 64501
Univ of KS-Kansas City 1967

Davin Turner, DO FP
802 N. Riverside Rd., #100
St. Joseph, MO 64507
Okla St Univ Col Osteo Med-Tulsa 1992

CALLAWAY

Christina Hicks, MD PD
1 E. 10th St.
Fulton, MO 65251
Univ of MO-Columbia 1994

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Thomas Oetting, MD OPH
1101-D Southwest Blvd.
Jefferson City, MO 65101
Duke Univ-Durham, NC 1991

Jeffrey Sanders, MD IM
1505 Southwest Blvd.
Jefferson City, MO 65109
Univ of MO-Columbia 1983

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Daniel Bosso, DO FP
3231 S. National
Springfield, MO 65807
Univ of Hlth Sci Col of Osteo Med-Kansas City 1984

Mai Vo, MD PD
3443 S. National Ave.
Springfield, MO 65807
Louisiana St Univ Med Ctr-Shreveport 1993

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3772 Washington St., #B
Kansas City, MO 64111
Univ of MO-Columbia 1997

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St. Louis, MO 63108
Emory Univ Sch of Med-Atlanta, 1996

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724 Belvedere Ln.
St. Louis, MO 63122
St Louis Univ 1996

Donald Ward, MD OBG
5592 Waterman Blvd., #A-1
St. Louis, MO 63112
Univ of Louisville-KY 1997

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